REPORT OF THE ADVISORY COMMITTEE ON ALCOHOL AND DRUG ADDICTION TREATMENT AND PREVENTION SERVICES ON PRINCE EDWARD ISLAND

TO

THE MINISTER OF HEALTH
PROVINCE OF PRINCE EDWARD ISLAND

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Honourable Fred Driscoll
Minister,
Department of Health
P. O. Box 3000
Charlottetown,
Prince Edward Island

Dear Mr. Driscoll:

We hereby submit the report of the Advisory Committee on Alcohol and Drug Addiction Treatment and Prevention Services on Prince Edward Island. The Committee was established in November, 1978, by your predecessor in office, the Honourable A. E. Ings.

The members of the Committee wish to thank those who submitted briefs and made presentations; these have been of great assistance. They wish, too, to express their appreciation of the interest that both you and Dr. Ings have shown in the Committee's work.

We are aware that the composition and the authority of the Committee have been questioned prior even to the publication of our Report, and that our findings and recommendations are likely to prove controversial. We have thought it best, therefore, to openly admit our biases where they exist, and to speak our opinions plainly, on the assumption that to have done otherwise would not have been helpful. We have attempted a clear exposition of the nature and origins of the conflicts that have beset the field of alcoholism treatment services in the province, in the hope that the constructive discourse essential to improvements in service can proceed in a civilized fashion, and that personal differences may come to be seen as no more than incidental to general themes.

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We have emphasized the political nature of decisions that must be made to permit advance, and we have put forward what we consider to be a realistic and workable proposal to assure the best possible quality of service to addicted persons in our Province, and one which, we hope, will prove beneficial to the Island as a whole.

Respectfully submitted,

Marvin R. Clark, Chairman

Philip Arbing

Andrew Hutchinson

Patricia Bruce

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William Macdonald

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Michael Hennessey

Benjamin Spears

Sharon Fortier, Secretary

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SUMMARY OF RECOMMENDATIONS

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GENERAL:

Recommendation # 1 — 48
That the present level of funding of addiction services by government be maintained or increased.

Recommendation # 2 — 48
That services, where possible and feasible, be purchased from private bodies or agencies

ADMINISTRATIVE:

Recommendation # 3 — 50
That the Community Hospital Boards assume regional management responsibilities for the facilities and programs now administered in Summerside, Charlottetown and Souris by the Addiction Foundation, in accord with the principle of decentralization of management. However, this does not restrict future involvement of other Community Hospital Boards.

Recommendation # 4 — 51
That the boards of these hospitals appoint Addiction Advisory Committees, of professional and non-professional community members.

Recommendation # 5 — 57
That the Hospital Services Commission become the central, co-ordinating, standards-setting, and funding body for addiction services in Prince Edward Island

Recommendation # 6 — 57
That an expert consultant be added to the staff of the Hospital Services Commission.

PAGE NUMBER

TREATMENT:

Recommendation # 7 58

That the facilities in Summerside, and Souris continue to be the location of active in-patient detoxification services, and out-patient rehabilitation and after-care, and, should their management be assumed by the community hospital boards, that each become known as a county Alcoholism and Drug Addiction Treatment Centre (ADATC), a title which should help to dispel their identification as simple detoxification units.

Recommendation # 8 59

That the ADATCs introduce a system of medical/nursing screening for all cases prior to admission. This should be available on a 24-hour basis.

Recommendation # 9 59

That the ADATCs develop close links with the local government service office of the Department of Social Services, and with volunteer bodies, for the provision of emergency social relief for alcoholics and their families.

Recommendation # 10 60

That the ADATCs develop out-patient detoxification services.

Recommendation # 11 60

That ADATCs make efforts to reduce the number of beds available for detoxification.

PAGE NUMBER

TREATMENT:

Recommendation # 12 60
That separate areas for the use of women patients be developed within the in-patient facilities.

Recommendation # 13 61
That ADATCs accept the authority to detain compulsorily admitted patients under the terms of proposed legislation.

Recommendation # 14 61
That ADATCs acquire a capacity for comprehensive assessment.

Recommendation # 15 62
That ADATCs develop intensive out-patient rehabilitation programs.

Recommendation # 16 63
That ADATCs develop a system of after-care.

Recommendation # 17 63
That without delay the provincial co-ordinating body develop by-laws, rules, treatment guidelines, and regulations for the ADATCs, and that, thereafter, open-admission policies for physicians be considered.

Recommendation # 18 65
That government support the contracting out of residential and day-care rehabilitation facilities in Queen's County as a provincial resource.

PAGE NUMBER

TREATMENT:

Recommendation # 19 — 65
That Government encourage an association between ADATCs and an approved centre of excellence such as Donwood.

Recommendation # 20 — 66
That community hospital boards assume management for half-way houses.

Recommendation # 21 — 66
That government support private initiatives to establish hostels for indigent alcoholics.

Recommendation # 22 — 68
That recovering alcoholic para-professionals be employed in significant numbers of alcoholism treatment services.

Recommendation # 23 — 70
That the Alcohol and Drug Addiction Treatment Centres provide effective training programs in alcoholism to the workers in community agencies.

Recommendation # 24 — 70
That the Alcohol and Drug Addiction Treatment Centres develop formal contractual links with the Community Mental Health Service Branch of the Division of Mental Health.

Recommendation # 25 — 72
That the Diversionary Project be subject to immediate evaluation by the co-ordinating authority.

TREATMENT: PAGE NUMBER

Recommendation # 26 73

That evaluation be incorporated at the outset into every developing program.

Recommendation # 27 74

That the central co-ordinating body seek assistance from centres of excellence with the development of evaluation.

PREVENTIVE:

Recommendation # 28 79

That there be an increased emphasis on and support for prevention aspects of addiction services.

Recommendation # 29 80

That the major thrust in addiction prevention services be composed, in order of priority, of:

(a) Comprehensive addiction education for young people through the public school system;

(b) Public awareness through media;

(c) Available education programs for demonstrably at-risk groups such as children of alcoholics and residents of senior citizens' homes.

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PREVENTIVE:

Recommendation # 30 83

That prevention programming focus on:

(a) Education in the area of making reasonable, mature, and responsible decisions regarding alcohol and drug use;

(b) The development and availability of meaningful lifestyle alternatives not contingent upon alcohol or drug dependence;

(c) Growth in the knowledge and acceptance of one's strengths and capabilities.

Recommendation # 31 83

That all prevention programming be consistent with the general principle that good health is preferable to poor health. Further, no particular religious, political, or racial prejudice should be promoted by any program offered, and no individuals delivering any prevention program should themselves be misusing the substance or substances in question.

Recommendation # 32 84

That full responsibility for the coordination of alcoholism prevention programming directed toward the school population, and the provision of addiction materials to school groups, be placed upon the pertinent divisions of the Provincial Department of Education, in co-operation with the central co-ordinating body responsible for addiction services.

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PREVENTIVE:

Recommendation # 33 — 84
That responsibility for community prevention programs not aimed at the school population should lie with the funding and co-ordinating body for addiction services, the delegation of programs being made to appropriate agencies or departments.

Recommendation # 34 — 85
That government make every effort to have advertising of alcoholic beverages banned from Cable TV.

Recommendation # 35 — 85
That a program of counter-advertising be supported by government, linking positive lifestyles with alcohol-free and drug-free living.

Recommendation # 36 — 86
That a surveillance system be organized by government to monitor the abuse of drugs of addictive potential obtained by prescription or through false or misleading information.

Recommendation # 37 — 86
That the co-ordinating and directing body, direct attention to supporting family units where addiction is a problem.

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Recommendation # 38 89

That a Committee of members of the Department of Justice, the police, and the Prince Edward Island Bar Society be struck immediately by government to carry out a complete review of legislation bearing on addictions, and to bring forth comprehensive legislation.

Recommendation # 39 89

That developed comprehensive legislation include the following:

- a clear definition of addictions;
- a definition and outline of services and programs;
- assignment of responsibility for services and programs;
- provisions of accountability;
- clarification of jurisdictions whether public or private;
- provisions of participation of community interests;
- clarification of the liability question concerning staff, clients , and others;
- voluntary and compulsory measures;
- minimum standards;
- evaluation of programs.

Recommendation # 40 90

That a research body to conduct comparative outcome, epidemiological, and utilization studies be formed immediately to provide services for the Committee working on comprehensive legislation.

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Recommendation # 41 — 93
That a minimum period of detention for treatment be defined and authorized in new addictions legislation, for those addicted persons compulsorily admitted as a result of medical examination to treatment facilities, with the provision that discharge on clinical grounds prior to the expiry of the authorized period continue to be possible.

Recommendation # 42 — 95
That authority to detain those ordered into treatment in lieu of paying a fine or imprisonment, be clearly outlined in legislation.

Recommendation # 43 — 95
That those with responsibility for applying legislation that may provide treatment in lieu of a fine or imprisonment, be encouraged to use these provisions.

Recommendation # 44 — 96
That the necessary legislation be developed to decriminalize public drunkenness.

Recommendation # 45 — 96
That in the case of publicly intoxicated individuals taken to addiction treatment facilities by law enforcement officers, a minimum period of authority of up to 72 hours for detention for purposes of emergency assessment and treatment be defined in new legislation.

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Recommendation # 46 97
That all addiction facilities in the treatment system develop the capacity to detain individuals within the constraints of the law.

Recommendation # 47 97
That legislation under Sections 11, 12 and 13 of the Mental Health Act be amended to clearly state where the person should be taken and what category of person (psychiatrist, medical doctor, etc.) should carry out the examination.

Recommendation # 48 98
That the powers of entry into a domestic dwelling under certain circumstances be made explicit in any new legislation.

Recommendation # 49 98
That legislation regarding transfer of patients be reviewed in order to clarify it.

Recommendation # 50 99
That, with reservation, the Jails and Prisoners Act be amended to outline clearly that only under exceptional circumstances should anyone be admitted to a jail/lock-up facility for being intoxicated in a public place, and only after a medical assessment has been performed.

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	PAGE NUMBER
Recommendation # 51 That the staff complement of liquor inspectors with authority under the Liquor Control Act be increased with particular attention being paid to: - the inspection of licensed premises; - the use of mandatory identification; - under-age drinkers.	100
Recommendation # 52 That the Liquor Control Act be reviewed with a view to shifting the burden of proof to the bootlegger to account for his supplies of liquor.	101
Recommendation # 53 That the drinking age in Prince Edward Island be raised to 19, thus making the age uniform in the Maritime Provinces.	101
Recommendation # 54 That the government take steps to promote a discussion of the legal drinking age at the national level with a view to making it uniform.	101
Recommendation # 55 That the procedures and criteria under which licenses and special permits are granted, be reviewed and tightened.	102

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Recommendation # 56 103
That the experience since the amendment regarding the transportation of open liquor in automobiles was proclaimed in September, 1975, be evaluated with a view to re-writing the legislation in order to clarify it and make it enforceable.

Recommendation # 57 103
That prevention be given appropriate attention in legislation, by at least assigning special prevention responsibilities to particular services or agencies.

Recommendation # 58 104
That employees' rights and duties regarding treatment for alcoholism be given appropriate attention in labor-management negotiations, and be reflected in other pieces of provincial legislation and regulations.

Recommendation # 59 106
That the criteria set and the procedures used to obtain an operator's license be reviewed with a view to improving highway safety.

Recommendation # 60 106
That a Medical Advisory Panel to the Highway Safety Division be established to make judgements on granting or reinstating the operators' licenses of applicants referred to it.

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	Recommendation # 61 That regulations under the Highway Traffic Act be amended with a view to requiring all individuals convicted of drinking and driving type of offenses under provisions of the Criminal Code to participate in a Driver Rehabilitation Course.	107
	Recommendation # 62 That upon first application, or application for renewal, and before receiving an operator's license, a condition of obtaining that license should be that, in the event of an accident, the individual gives consent to the police and/or the medical profession to obtain a blood and/or urine sample if breathalyzer samples and/or other evidence is deemed appropriate.	108
	Recommendation # 63 That government continue its present policy of allowing no advertising of alcoholic beverages in media within the province.	109
	Recommendation # 64 That the provincial government examine as soon as possible the whole question regarding confidentiality, the right of data collection, ownership of information, exchange of information, and develop policy positions on these matters.	111
	Recommendation # 65 That the province establish a method whereby individuals may have access to legal services to exercise their rights in dealing with the negative aspects of addiction problems.	112

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Recommendation # 66 — 112

That the province make its position known to the Federal Government on the matter of addictions and, where a position does not exist, to develop one.

Recommendation # 67 — 114

That the Department of Justice undertake a systematic review of the Criminal Code provisions that have potential for facilitating intervention into and management of family disputes/violence attributable to abuse of alcohol and drugs.

Recommendation # 68 — 114

That in situations where satisfactory remedies short of placing the matter before the courts cannot be found, government through the Department of Justice, should develop mechanisms to bring matters such as domestic disputes which may involve assault first before the family courts, as opposed to the practice of bringing them before provincial court where proceedings are more open to the public.

Recommendation # 69 — 115

That the province, through agencies such as the Atlantic Police Academy, develop and administer to all law enforcement people a minimum standard of training in the area of crisis intervention.

INTRODUCTION

Membership

- Marvin R. Clark, M.A., M.D., C.C.F.P.
  Deputy Minister of Health

- Philip Arbing
  Director of Probation and Family Court Services
  Department of Justice

- Patricia Bruce, B.S.W.
  Program Development Specialist
  Department of Social Services

- Sheldon Cameron, M.D.
  Summerside, Prince Edward Island

- Keith Cooke
  Board Member of Prince Edward Island Addiction Foundation

- Sharon Fortier
  Secretary to Advisory Committee

- Michael Hennessey, B.A., B.Ed.
  Registrar
  University of Prince Edward Island

- Andrew Hutchinson, B.Sc. (Hon.)
  Youth Projects Officer
  Division of Youth Fitness and Recreation
  Department of Education

- Lloyd King
  Crossroads, Prince Edward Island

- William J. R. Macdonald
  Chief of Police
  Summerside, Prince Edward Island

- Lemuel E. Prowse, M.D.
  Chairman, Hospital Services Commission

- Benjamin Spears, M.B., M.R.C., Psych., D.P.M.
  Charlottetown, Prince Edward Island

- Reverend Ronald Vincent, B.A., M.Div.
  Montague, Prince Edward Island

- Ernest MacDonald, B.A., B.S.W., M.S.W. (Dec./78 - Feb./79)
  Executive Director
  Addiction Foundation of Prince Edward Island

- Lorne R. Moase, B.A., B.Ed., M.Ed. (Nov./78 - Apr./79)
  Deputy Minister of Education

- Frank Zakem, B.A., B.Ed., B.Admin. (Nov./78)
  Principal, Holland College Charlottetown Centre

Terms of Reference

The Advisory Committee which was created by the authority of Cabinet and designated as a Ministerial Committee, was charged with the responsibility of reporting in 1979 to the Minister of Health. The Committee's function was to bring forward recommendations on provincial addiction and alcohol prevention and treatment services regarding:

a. Goals and objectives of alcohol and drug addiction treatment and prevention services on Prince Edward Island;

b. Government policy regarding alcohol and drug addiction treatment and prevention services on Prince Edward Island;

c. Agencies involved in alcohol and drug addiction treatment and prevention services on Prince Edward Island;

d. Extent of the addiction problem on Prince Edward Island;

e. Effectiveness/cost of alcohol and drug addiction treatment and prevention services on Prince Edward Island.

The Committee, under the Chairmanship of the Deputy Minister of Health, was composed of individuals of various backgrounds who possessed a common interest in the field of addiction treatment services. Although, for the most part, the members were representatives of particular groups, agencies, or departments of government, it was for their individual contribution that they were selected. All changes of membership were made with Ministerial approval.

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Briefs

Briefs were solicited both publicly through the media and by specific request from organizations, both within and without government, and from individuals who wished to express their opinion on the whole range of addiction services, or particular aspects thereof. The following individuals and organizations submitted briefs, some of which were presented personally at the Committee's meetings:

GROUPS:

- Addiction Foundation of Prince Edward Island
- Alcohol and Drug Problems Institute
- Alcohol and Information Council of Prince Edward Island
- Allied Youth of Prince Edward Island
- Association of Social Workers
- Catholic Family Services Bureau
- Council of the Disabled
- Department of Education
- Department of Justice - Ian Bailey, Department of Justice, served as Consultant to the Committee on legal matters
- Department of Social Services
- Guidance and Counselling Association of Prince Edward Island
- Hospital Association of Prince Edward Island
- Kings County Advisory Board
- Prince Edward Island Advisory Council on the Status of Women
- Prince Edward Island Medical Society
- Protestant Family Services Bureau and The Queen's County Ministerial Association
- Sign of the FISH
- United Church Women
- Women's Institute of Prince Edward Island

INDIVIDUALS:

- Fred Carver
- Peter Driscoll
- John Dunphy
- Tom Dunphy
- Bill Evans
- Helen Gill
- Joe MacKinnon
- Ruth MacRae
- Justin McKinnon
- Robert H. Roy
- Mary E. Slavin

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The Briefs, whose contents were studied in detail, with requests for clarification as necessary, proved helpful, particularly in the elucidation of public attitudes and expectations.

Resource Documents

In addition to studying the briefs, the Committee has made every effort to inform itself of current research and opinion in the area of addiction, prevention, identification, and treatment. The following were among resource documents utilized by the Committee:

- Addiction Foundation of Prince Edward Island Act and Amendment, 1975-1976
- Alcoholism and Mental Health Services on Prince Edward Island - Dr. Killorn
- Atlantic Consultation: Women, Alcohol and Other Drugs
- Barriers to Effective Implementation of the Uniform Alcoholism and Intoxification Treatment Act - D.J. Pitman, 1977
- Core Knowledge in the Drug Field, 1978 (12 Volumes)
- Decriminalizing a Victimless Crime - Pastor, 1977
- Liquor Control Act of Prince Edward Island, 1975/1977
- Maryland Laws on Alcoholism
- Mental Health Act Regulations and Amendments
- Models of Madness - Models of Medicine - Siegler and Osmond - MacMillan and Co.
- Motivation, Responsibility and Sickness in the Psychiatric Treatment of Alcoholics - P. Davies - British Journal of Psychiatry, 1979
- Prince Edward Island Alcoholism Research Report, November, 1973

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- Proposal to Develop a Comprehensive Drug and Alcoholism Treatment Program in the Annapolis Valley
- Rand Foundation - Report on Alcoholism, 1976
- Report of the Mental Health Advisory Committee to the Minister of Health, May, 1978
- Report of the Premier's Task Force on Extended Care and Alcoholism Treatment Facilities on Prince Edward Island, March, 1969
- Report of the Survey of the Treatment Services of the Addiction Foundation of Prince Edward Island - Boothroyd, July, 1978
- Revision of Wisconsin's Law of Alcoholism and Intoxification - J.J. Robb, 1975
- Selected Papers of Eliot Slater: Shields and Gottesman - John Hopkins Press
- The Future of Alcohology - Kalb and Propper, American Journal of Psychiatry, 1976
- The Treatment of Alcoholics: An Ontario Perspective, 1978

The reader will find it useful to read the Boothroyd Report in conjunction with the Committee's. The detailed descriptions of the services and facilities of the Addiction Foundation and of the Alcohol and Drug Problems Institute have required no duplication.

A serious shortcoming of the Report stems from the shortage of informative statistics and studies which would have provided the best instruments for reasoned argument. In general, the basic data obtained from the various agencies involved in addictions' treatment were found to be unsatisfactory in their present form, providing at best, crude indicators of utilization patterns and little more.

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The unique economic and cultural characteristics of Prince Edward Island, aptly and picturesquely described in the Boothroyd Report, suggest to the Committee that to transpose and to apply findings wholesale from other areas to this Province may be a fundamental error. Without local epidemiological, comparative outcome, and utilization studies, argument is prone to rely on opinions and assertions that may prove in time to have been unwarranted, and can exist only at an unsatisfactory level of generality. With certain data unavailable to it, the Committee has found it impossible to meet some of its terms of reference particularly in regard to cost-benefit of treatment services. Nevertheless, the Committee believes its report represents the result of a thorough and comprehensive local and general investigation.

Definitions

For purposes of brevity, the Committee in its report has chosen to stay with the single term, "Alcoholism," allowing that assumed under this rubric may be a heterogeneous group of disorders, and that some inevitable and potentially misleading simplification may ensue. Terms such as "problem drinking," "dependent drinking," and "alcohol dependence syndrome" have not been used. The Committee simply proposes a broad operational definition of alcoholism, which refers to those episodic or continuous uses of alcohol which cause therapeutic concern.

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Because of the heterogeneous nature of alcoholism, the use of the single term may, at times, convey to the reader a composite picture likely to correspond to the classical view of the alcoholic, which some view as a suspect stereotype, including physiological and psychological dependency, loss of control, and the likely occurrence of withdrawal effects on cessation of drinking. The proportion of alcoholics who conform to this classical picture at any given time in Prince Edward Island is not known to the Committee, but the utility of a narrower formal definition lies in its describing the gravest component of alcoholism in terms of human suffering and social costs. Because there does not appear, to the Committee, to be any particular necessity for separate services for treatment of addictions other than alcohol, drug addictions, unless mentioned specifically in the text, may, in this Report, be assumed in the term alcoholism.

Finally, it must be said that if our Report appears, at times, critical, no imputation of bad faith is intended. All who work in addiction treatment services merit the greatest respect, and the Island is in their debt. Some error in the planning and development of new treatment and prevention services in a field of such appalling complexity as alcoholism is inevitable. We agree with Dr. Boothroyd that the foundation of an exemplary system of service is now in place, and our recommendations are intended to expedite the achievement of such services.

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PRESENT SERVICES

1. History of Development of Alcoholism Treatment Services and Related Government Policy

The development of formal treatment services of alcoholism in Prince Edward Island differs from that of other Canadian Provinces only in that it began slightly later, as might have been expected in the province that was last to abandon prohibition, which it did in 1948, with the two political parties divided on the issue. The laws governing the use and sale of alcohol are said to have been the strictest in Canada with penalties for offences ranging from $200 minimum fine for the first offence, to a maximum of twelve months imprisonment for the second. The Temperance Act of 1948 permitted the purchase of one bottle of liquor or one case of beer a week. Only in 1964 were public facilities permitted to sell alcoholic beverages.

Although government had evinced some interest in providing services for the families of convicted alcoholics in 1943 when social workers were appointed by the Lieutenant-Governor-in-Council, specialized services for alcoholics themselves resulted from a citizens' movement. With generous assistance from the Roman Catholic Diocese of Charlottetown, and the obtaining of federal funds, the Alcoholism Treatment Foundation (A.T.F.) was established in 1966, operating from the Talbot House in Charlottetown. Hitherto, alcoholics had been admitted to general hospitals for medical treatment and detoxification.

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The provincial psychiatric hospital admitted many alcoholics for purposes of detoxification, and at times, depending on available resources, offered special treatments including group, abreactive, and adversive therapies, but gradually discontinued its rehabilitation function as the A.T.F. developed its own treatment programs.

The Report of the Premier's Task Force of 1969 which still stands, ten years later, as the most thoroughly researched and best documented provincial study of alcoholism, proved a landmark in service development and influence upon the formation of subsequent government policy.

THE MAJOR GENERAL EFFECT OF THE REPORT WAS THE ACCEPTANCE AT THE OFFICIAL LEVEL OF THE DISEASE CONCEPT OF ALCOHOLISM WHICH THE TASK FORCE HAD BEEN AT PAINS TO PROMOTE, REFLECTING A PROCESS COMMON TO MANY JURISDICTIONS IN NORTH AMERICA AT AROUND THE SAME TIME.

The importance of this new understanding by government cannot be over-estimated, leading, as it did, to altered social dealings with the alcoholic who now came to be viewed as a sick person deserving of treatment, whereas, formerly, he had been seen, at best, as worthy of benign compassion, and, at worst, of contempt and punishment. Locally, as elsewhere, the members of the organization Alcoholics Anonymous over the years had been instrumental in effecting this profound change in social attitude which formally crystallized in the Task Force's Report.

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After the publication of the Task Force's Report, the A.T.F., became officially recognized as the provincial agency for alcoholism treatment.

The Department of Social Services served as the conduit of the provincial contribution which grew annually. In 1970, the A.T.F. was able to open a 25-bed detoxification centre in its premises on University Avenue; the Talbot House discontinued its own detoxification service and functioned thereafter as a halfway house.

No longer hampered to the same extent by the inadequate financing of the first years, the A.T.F. expanded its programs, acquiring another halfway house in Prince County, operating a residential rehabilitation service in Charlottetown, developing educational services, and conducting studies.

In 1974, however, following internal disagreement, the A.T.F.'s medical director resigned to subsequently establish the private Alcohol and Drug Problems Institute, and carried with him a large fund of public gratitude and loyalty, particularly that of the A.A. membership. The intense bitterness generated during that period has yet to dissipate, and a schism developed in provincial alcoholism treatment services which has persisted to the present day.

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Following a period of study of the legal authority of the Addiction Treatment Facility, and an evaluation of the treatment program by Development Planning Associates Limited, government proclaimed the Addiction Foundation Act of Prince Edward Island in 1975 establishing the Addiction Foundation as an independent Crown Corporation responsible to the Minister of Health. Additional to the Chairman and four private members, the board was composed of four members of government departments, namely, Education, Health, Justice, and Social Services.

The Act, which took a sophisticated view of the serious and complex nature of alcoholism, recognized the need for a multi-dimensional approach, and called for a co-operative effort by all professional bodies and institutions. It gave the Foundation a broad mandate with responsibility for providing addiction treatment and prevention services in all their aspects, and for the co-ordination of other agencies' services for alcoholics.

Since 1975, there has been a rapid burgeoning of facilities and personnel within the Addiction Foundation; notably, there has been a significant influx of health care professionals other than physicians and nurses. Prince County, with generous assistance from the board of the Prince County Hospital, developed detoxification services as, subsequently, did Kings County. In 1978, a Diversionary Project was developed, establishing on Kent Street in Charlottetown a facility to serve as an initial detoxification centre for arrested public inebriates who would otherwise have been jailed. A farm for the long-term care of the chronic alcoholic has been

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purchased in Fredericton, Prince Edward Island, but is not yet in operation because of budgetary restrictions and unresolved issues of program definition.

Any survey of government policy since 1969, in fact, reveals a remarkable consistency with the recommendations of the Premier's Task Force.

The recognition of alcoholism as a treatable condition has resulted in a provincial funding of treatment services which now, according to the Boothroyd Report, exceeds that in relative terms of any other Canadian Province. Since there is no evidence that alcoholism is more prevalent in Prince Edward Island than elsewhere in Canada, this remarkable generosity of funding speaks much for the decency of government and the citizens of our province.

Since the introduction of Medicare in 1970, the Health and Hospital Services Commissions have as a matter of policy insured the costs of hospital and medical services to alcoholics, including medical services performed within the precincts of the Addiction Foundation's facilities and within the private Alcohol and Drug Problems Institute. The general hospitals of the province have continued to admit alcoholics in need of medical investigation and treatment, and occasionally those simply in need of detoxification.

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Since 1973, provincial court judges have been empowered to order compulsory treatment for those alcoholic offenders arrested three or more times within a period of six months, although an order to this effect has rarely been used, ostensibly because of the lack of an appropriate facility where such treatment might be carried out.

As recommended in the Premier's Task Force Report, in 1974 an amendment was made to the Mental Health Act to provide for statutory treatment for alcoholics on the fulfillment of certain criteria which do not differ from those which apply to individuals suffering from other types of mental disorder.

For many years, the Department of Education has contained within it the "Allied Youth" organization, which authorized excellent research studies on the incidence of drinking in schools and has provided a preventive educational service of the highest quality. The Unit School Boards have invited outside agencies, including the Addiction Foundation and the Alcohol and Drug Problems Institute, into the schools for the purpose of preventive education both for teachers and students. Unfortunately, no evaluation on the response to or effectiveness of these programs has been made.

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A preventive emphasis in the approach to alcoholism was first made explicit by the terms of the Addiction Foundation Act of 1975. The Committee understands the passing of the Act to have been accompanied by a desire on the part of the civil authorities to move towards the decriminalization of public drunkenness, de facto if not de jure.

If, indeed, this was the case, then a notable alteration in judicial practice may reasonably be inferred: that is, that with respect to alcoholism, the deterrent and reformatory aspects of judicial punishment were to be abandoned as being of limited effectiveness, and replaced by a more pragmatic course of action, based on referral for treatment. The intent of government to decriminalize public inebriation appears confirmed by the intended policy of excluding from the new Queen's County Correctional Centre arrested public inebriates.

The arrangements made by government for its own alcoholic employees, through the regulations of the Civil Service Act, are generous and might well serve as a model for other large employers in the Province. Alcoholism is treated as any other illness and, when recognized, referral is made for treatment. Seminars on alcoholism are regularly arranged for Civil Service supervisory staff to enable an early recognition of alcoholism in employees, and determined steps to confront the problem of alcoholism have been taken by several government departments.

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It is recognized that all governments which sell and tax liquor, and control outlets through the issuing of licenses, find themselves confronted with the contradiction of simultaneously growing revenue and growing expenditures caused by the social costs of alcoholism. Naturally, the Government of Prince Edward Island has not been exempt from this paradox.

The past several years have seen a distinct liberalizing of policies governing the sale of liquor. In 1974 the drinking age was lowered to 18, and the number of liquor outlets has grown rapidly in recent years. Against this growing liberalization, might be weighed the fact that Prince Edward Island remains the only province to ban all types of liquor advertising.

Despite the vastly increased public expenditures on alcoholism treatment services, the Committee believes that services for alcoholics remain inadequate.

Additionally, there has been a good deal of publicly expressed disagreement with some of the activities of the Addiction Foundation, particularly by alcoholism advocacy groups and individuals. Questions concerning these activities have been asked in the legislature and, with respect to the treatment of alcoholics, at times government departments have found themselves at odds with each other.

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That the government in the face of these publicly-voiced dissatisfactions should have reacted to constrain the growth of the Addiction Foundation in the past two or three years is hardly surprising. While the exercise of budgetary restraint has undoubtedly increased tension between the Addiction Foundation and the government, the Committee can adduce no evidence whatsoever that such restraint reflects any change in government's enlightened and generous attitude towards the alcoholic in recent years. Government has grasped clearly that well-intended social action should proceed only with caution when unsupported by evidence, and the existence of our Committee equally testifies to the adoption of this principle.

II. Magnitude of the Problem

The prevalence of clinical alcoholism in Prince Edward Island is unknown, but it is likely that up to 90 percent of the adult population drink alcohol in varying degrees. The per capita consumption of alcohol here in 1974 still fell in the lower range for Canadian provinces, despite the fact that the rate of increase from 1967-1974 of alcohol consumption was double the national average of 30 percent. Recent studies have suggested that any increase in per capita consumption is reflected by an increase in the number of alcoholics, the implication being that alcoholism is a serious growing problem. It is worthy of note, however, that in 1978, the provincial government's profit on alcohol sales was $9,988,000, a sum that considerably exceeded the designated expenditures on alcoholism treatment and prevention services.

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In Prince Edward Island, according to the data for service demands, the proportion of male to female alcoholics is the order of 20:1, although observations of family and group protection of the female alcoholic suggest that ratio to be erroneous. No socio-economic class gives evidence of exemption from the condition. The Department of Social Services has brought to the Committee's attention the growing incidence of alcoholism in residents of institutions for the elderly, but most alarming to the Committee were the findings of a school study by the Alcohol and Drug Problems Institute under the auspices of Allied Youth, indicating that between 1972 and 1976, the number of teenage students drinking had increased by 18.7 percent, and that 85.1 percent of Grade XII students drank. Further, it is the Committee's considered opinion that increased drinking is also more prevalent among younger students, as is illegal drug use.

INCIDENCE OF REPEATED ALCOHOL USE BY GRADE, 1972-76
(In Percentage)

GRADE	1972	1976	DIFFERENCE
7	22.5	40.3	17.8
8	35.8	51.6	15.8
9	43.2	67.5	24.3
10	52.0	71.1	19.1
11	56.7	72.9	16.2
12	67.7	85.1	17.4
TOTAL:	45.8	64.5	18.7

An important and frequently reported phenomenon in recent years is that of multiple-addiction. The minor tranquillizers, of which Valium is probably the best known, have come, of late, to be recognized as drugs of addictive potential, and in excess of 50 percent of admissions for in-patient detoxification are for abusing tranquillizers as well as alcohol. Because of the startling and questionable frequency with which drugs such as Valium are prescribed, and since they have become more freely available on the illicit market, their abuse has become more widespread. Indeed, a minor tranquillizer may now represent a more economical substance for abuse than alcohol. It is reported that in the United States today, 30 percent of the adult population are taking Valium for at least three months in the year.

Of the illegal street drugs, marijuana is the only one significantly increasing in use on Prince Edward Island. Studies indicated that in 1976, 23.6 percent of high school students used marijuana. It ranks third in use behind alcohol and tobacco. This figure indicates a significant increase of 10.3 percent over 1972 figures and there is no indication that the rate of increase is levelling off. Recent studies from the United States show that marijuana is used as frequently as is alcohol among the adolescent population.

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Other studies indicate that the average potency of the active ingredient in the drug, Delta-THC, has increased almost fourfold since 1970, from 1 to approximately 4 percent.

Although research into the long-term effects of marijuana use is not as advanced as for alcohol, a substantial and growing body of findings indicates that the cellular effects resulting from marijuana use are damaging both physically and mentally. The health and social costs now partially hidden or just now developing may well be staggering.

The largest single term in the economic cost of alcoholism in Canada is said to be loss of production, which was conservatively estimated in 1974 at a billion dollars. Nationally, the annual cost of motor vehicle accidents, fatalities, and property damage caused by alcoholism, has been estimated at 650 million dollars, and 50 million dollars a year is the cost of alcohol-related crime. Fifty percent of homicides and 50 percent of homicide victims have been alcohol abusers. The high degree of association of suicide with alcoholism has been well demonstrated in Prince Edward Island, as elsewhere.

The extent of the costs imposed on the health care system, related to medical and psychiatric services, is incapable of measurement, and far exceeds the amount of the Addiction Foundation's budget. The medical complications of alcoholism are many and varied and frequently are treated in ignorance of their original cause.

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Studies have shown that in some districts up to 50 percent of general hospital in-patients are suffering from often unrecognized alcoholism.

The general hospitals of the province continue to admit and treat significant numbers of individuals with a primary diagnosis of alcoholism, and the figures obtained by the Committee are certainly inaccurately low. It is possible that the rate of alcoholic admissions to the general hospitals in Charlottetown has decreased since the opening of the Kent Street facility, as had originally occured in Hillsborough Hospital, although such a decrease is not obvious as a general impression.

TABLE 1

Admissions of Patients to General Hospitals with Primary Diagnosis of Alcoholism in 1977:

Charlottetown Hospital	138	
Community Hospital, O'Leary	25	
King's County Memorial Hospital, Montague	86	
Prince County Hospital, Summerside	86	
Prince Edward Island Hospital, Charlottetown	58	
Souris Hospital	52	
Stewart Memorial Health Centre, Tyne Valley	8	
Western Hospital, Alberton	88	
TOTAL:	541	
Average Length of Stay:	5 days	
COST:		$270,500

Additional to provincial hospital costs, the Hospital and Health Services Commissions pay the costs of treatment of alcoholics in treatment units elsewhere in Canada and in the United States, such as Donwood Institute in Toronto, Chit Chat Farms in Pennsylvania, and the West Palm Beach Institute in Florida.

TABLE 11

Patients Referred to Alcoholism Treatment Hospitals Out-of-Province in 1979:

Number of Patients	28	
Average Length of Stay	32	days
Estimated Cost		$80,000

The cost of physicians' services borne by the Health Services Commission for treatment at the Alcohol and Drug Problems Institute, at the in-patient units of the Addiction Foundation, at general hospitals and at Hillsborough Hospital cannot be accurately calculated, but an annual figure of $300,000 would likely fall short of the total. The additional cost of physicians' services for treatment of the medical complications of alcoholism such as accidents, and heart and liver diseases must greatly exceed this amount.

The Department of Health, which governs Hillsborough Hospital and the Riverside Home for Special Care, incurs significant costs in treating admitted alcoholics. These facilities receive all those whose condition is such as to warrant compulsory admission

under the Mental Health Act, of whom a small number are subsequently transferred to the Addiction Foundation. The number of admissions to Hillsborough Hospital fell sharply after the opening of the Kent Street facility but began to increase again in early 1979.

The major provincial health care service provider, however, for alcoholics, is the Addiction Foundation. For the past year, 1977-1978, $612,704 of the total budget of $1,213,921 was spent in the treatment of alcoholics in an in-patient detoxification setting, the remaining sum being assigned to administration, rehabilitation, prevention, and follow-up.

The tables below outline the institutional costs and the utilization patterns in the treatment of alcoholics. To be noted, are the exclusion of costs of physicians' services, and the failure of the data to distinguish between the numbers of admissions and the number of patients treated.

TABLE 111

Admissions of patients to the Provincial Psychiatric Hospital with a Primary Diagnosis of Alcoholism in 1977:

Male Patients	240	
Female Patients	16	
Patients Compulsorily Admitted (Percentage of)	60%	
Total Number of Patient Days	4,362 days	
Cost		$170,000

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TABLE 1V

Admissions of patients to Facilities of the Addiction Foundation 1977-1978:

Queen's County

1. Detoxification Centre			
Number of Admissions	946		
Number of Patient Days	7,159	days	
COST			$284,570
2. Talbot House			
Number of Patients	47		
Number of Patient Days	2,538	days	
COST			$ 72,459
3. In-Patient Rehabilitation Program (operated for 10 months)			
Number of Admissions	81		
Number of Patient Days	648	days	
COST			$276,049

Prince County

1. Detoxification Centre			
Number of Admissions	990		
Number of Patient Days	5,304	days	
COST			$191,209
2. Saint Eleanor's Halfway House			
Number of Patients	47		
Number of Patient Days	5,304		
COST			$ 72,459

Kings County

1. Detoxification Centre (operated for 7 months)			
Number of Admissions	362		
Number of Patient Days	2,156		
COST			$ 80,871
		TOTAL:	$977,617

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TABLE V

TOTAL COST OF CARE IN ALL INSTITUTIONAL SETTINGS:	$1,498,117

The Department of Social Services, whose child welfare caseload increased by 13 percent from 1977 to 1978, has major dealings with the families of alcoholics rather than with alcoholics themselves, although requests for financial assistance and shelter by younger indigent alcoholics are growing. The Department reports that alcoholism is invariably the major factor in cases of child neglect and abuse, and, in cases of marital separation, for 85 percent of unsupported women receiving welfare assistance. Further, the abuse of alcohol and drugs is becoming increasingly associated with juvenile delinquency.

Additional services provided and funded by the Department to families of alcoholics include: visiting and teaching homemakers' services, day care, counselling, and child protection.

Private agencies, particularly the Catholic Family Services Bureau, receive frequent requests for service from alcoholics and their families. This agency, which has a long tradition of caring for the alcoholic population, for some time operated a hostel for indigent alcoholic men in Charlottetown, a service of great value in the Committee's view, but one which ended on expiry of a grant.

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Again, the cost of alcoholism to the provincial criminal justice system is not known to the Committee, but must be considerable. A 1976 survey performed by the Department of Justice covering a period of nine months showed that of a total of 2,402 admissions to the provincial jails, 1,553, that is 65 percent, involving 715 individuals, were on the grounds of public intoxication, and 273, that is 11 percent of the total, were for other alcohol-related offences. It is evident that at an average daily cost of $45.00 to keep a person in jail, the annual alcoholism-related expenditure is high.

In Prince County, despite the advent of a detoxification unit, admissions to the jail for public intoxication have continued to increase.

In Charlottetown, although the Kent Street facility was intended to divert arrested public inebriates from the prison system, it was reported to the Committee in May, 1979, that about 50 alcoholics were being admitted to jail each month from this facility.

As with all human services, a significant proportion of demands for alcoholism treatment is made by a particular minority of affected persons. The Addiction Foundation has estimated there is to be about 70 irrecoverable alcoholics in the Charlottetown area who are refractory to treatment but continue to demand service constantly. As yet, no means has been devised to appropriately assist this group.

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Economic costs notwithstanding, the gravest concern of a humane society must be for the appalling suffering and waste of life caused by alcoholism. There can be few Islanders who have not had the opportunity to observe firsthand the ravages of a disease which has a potential, if present trends continue, to assume at some time in the future the proportions of an epidemic. The Report of the Premier's Task Force stated that every alcoholic influences 15 persons around him. The effects of alcoholism in a family may show up a generation or more later. Certainly, it is the experience of mental health professionals that the children of adult alcoholics are over-represented in their caseloads.

The Committee concludes that in 1979, in Prince Edward Island, alcoholism and drug abuse are serious and costly problems whose full extent is not known. There are signs that the prevalence is growing. Drastic and hasty measures are not called for, but the moment for thoughtful consideration and action by government is at hand.

111. Prevailing Attitudes:

The Committee has no hesitation in stating that the era of prohibition has been left behind with relief, and that any temperance movement that may exist appears to have become largely inaudible. The Committee could not go unimpressed by the general acceptance today of the generous use of alcohol, and both prescribed and non-prescribed drugs. The recent movement to modify the penalties for marijuana use and possession tend to confirm this perception.

In Prince Edward Island, alcoholism is now almost universally accepted as a disease. The Committee was rarely able to detect evidence of reactionary or moralistic attitudes. Government's funding of services for alcoholics and their families is in no way resented, although there is real concern that public funds committed to alcoholism be spent in the most productive possible way. Of specific concern voiced to the Committee was the perception that widely available in-patient detoxification services without associated obligations to receive rehabilitative treatment might be reinforcing morbid drinking patterns.

Among organizations who presented briefs to the Committee, alarm existed at the growing and enormous economic costs resulting from alcoholism's association with crime, highway accidents, and physical disease. The growing emphasis in the past years on prevention as a strategy of health care does appear to have an effect on the public mind. There is a growing public appreciation of the importance of preventive measures, particularly with regards to the availability of alcohol for young people, and with society's dealings with the drinking driver. Much faith is being placed in the ability of education, particularly in the schools, to raise future generations of responsible drinkers. The apparent success of public campaigns against smoking suggest that the public would be receptive to similar campaigns against alcohol abuse.

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The Committee, however, could not detect any widespread sense of serious alarm about alcoholism that might suggest that any drastic measures to reduce consumption would be received with favor. If such measures should be deemed necessary in the future, undoubtedly a preliminary period of public education would be essential.

Advocates for Alcoholics:

This group of individuals appears to the Committee to be of the greatest interest and importance in that they represent a category of patient that has organized on its own behalf, which is virtually unique. In general, these advocates, who came from the A.A. membership, and, exceptionally, from religious institutions, such as the Roman Catholic Diocese of Charlottetown and its Family Service Bureau, have played a major part in the development of services for alcoholics on the Island.

The Boothroyd Report explained the importance of understanding the advocacy of the A.A. members stemming from their actions in the capacity of concerned citizens, rather than as organizational members, which the Committee regards as a point to be well noted.

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There are many reasons why an organization such as A.A. should be particularly strong in a small community such as Prince Edward Island and it is to be fully expected that alcoholism advocates may form a politically influential group. This group largely concerns itself with the distress and suffering of the alcoholic and his family members, in contrast to the general public concern with the social costs of alcoholism. A principal value, perhaps, of members of this group rests in their ability, based on experience, to offer guidelines for the development of programs and services, for instance, on the subject of compulsory treatment.

Their role in Prince Edward Island may be justly compared to that of the provincial branch of the Canadian Mental Health Association, which has been influential in supporting the interests of the psychiatric patient and in the development of mental health services in the province, but which has been largely silent with respect to the interests of alcoholics. Although the advocates for alcoholics have been disparaged for excessive zeal, it should be remembered that this very zeal was instrumental originally in obtaining funds for treating alcoholism.

The advocates for alcoholics have tended to be suspicious of the operations of the Addiction Foundation since its inception in 1975 because of the bitterness caused by preceding events. The

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inherent anti-professional bias of an organization such as A.A. which, the Committee believes, can be overstated, accompanied by the professionalization of the Addiction Foundation's services, did not make for an easy atmosphere, but the advocates' criticisms which were presented to the Committee did not seem founded on prejudice; they included: a lack of rehabilitation for alcoholics, an insufficient number of recovering alcoholics employed as treatment staff, and the inability of county advisory boards to influence the Foundation's decisions.

Professional Attitudes:

In many ways, the attitudes of professionals, other than those working directly in alcoholism treatment, were the most difficult to discern. Many expressed an interest in learning more of the condition without displaying any desire to do more. Reasons, such as lack of time and shortage of resources, which, no doubt, have substance, were offered to explain a lack of involvement. Certainly, the Committee could detect no sign of vigorous commitment to the concerted action called for by the Addiction Foundation Act in addressing the problem of addictions. What has been termed the "quest for the rewarding patient or client," that characterizes human service professionals, appears to have assigned a low priority to the treatment of the active alcoholic, which, admittedly, can prove to be arduous and disappointing work.

The Committee concludes that society must place the very highest value on those professionals who demonstrate an aptitude and commitment in the treatment of alcoholics, and that to deny this small group influence in service development is a mistake.

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IV. Existing Services: Strengths, Deficiencies and Causes

Progress in the provision of alcoholism treatment and preventive services in the past ten years has reflected sustained effort and genuine commitment within government, its departments and agencies, private organizations, and the public at large. Exceptional contributions have been made by the board and staff of the Alcohol Treatment Facility of 1966, by the Addiction Foundation, by the Alcohol and Drug Problems Institute, by the Roman Catholic Diocese of Charlottetown, and by members of Alcoholics Anonymous. Services for alcoholics are, in general, incomparably better today than at any time since the publication of the Report of the Premier's Task Force.

The existence of three county detoxification centres with 54 beds has made freely available and accessible across the province medical detoxification services of high quality at a lower cost than the services of general hospitals. As a result, it seems likely that community safety has increased and that the physical health of the alcoholic population has improved. Alcoholics Anonymous, which forms the backbone of rehabilitation services for the alcoholic, has close links with the detoxification centres and the Alcohol and Drug Problems Institute, whose own out-patient rehabilitation services have proved a major addition to the repertoire of services for the alcoholic since 1975. The person arrested for public drunkenness is now able, if he chooses, to avail himself of medical detoxification as an alternative to the "drunk tank" of the county jail.

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Nonetheless, despite what the Committee considers to have been adequate government principles, adequate funding, and the good faith of all concerned, the present system of services displays serious shortcomings. Although the Addiction Foundation Act took care to endow the Foundation primacy as a coordinating body, services now act in an insufficiently coordinated fashion impeding the processes of appropriate referral and placement. The functional isolation between, and sometimes within, different agencies has not been overcome. Particularly damaging has been the absence of adequate working relations between the Addiction Foundation and other health care institutions.

Particularly irksome to front-line workers, such as police and family physicians, is the lack of clarity or stability of admission criteria of various institutions, and the lack of knowledge of available services. The failure of institutions to clearly delineate their respective obligations to certain categories of alcoholic patients has resulted not only in occasional antipathy between the institutions, but has led at times to distressing and potentially dangerous incidents.

Anomalies in practice that have approached the absurd have ensued from the failure of the Addiction Foundation and Alcohol and Drug Problems Institute to reach a productive accommodation. Both the private Institute and the Addiction Foundation have been invited by school boards to lecture to staff and students, promoting, presumably, different models and philosophies. The Civil Service for government's own addicted employees, exclusively uses the private Institute for treatment purposes, as does the Provincial Psychiatric Hospital for its alcoholic in-patients.

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Moreover, the Institute's Medical Director serves as advisor to the Department of the Provincial Secretary and to the Department of Justice, with the latter department having representation on the Addiction Foundation Board.

While some competition between human services agencies may be productive and healthy, with regards to the case in point this has not proved to be so. The Act of 1975, which opened the way to the Foundation's contracting with private agencies to provide service, very much in keeping with modern policy of governments, has been frustrated in this particular intent to the detriment of alcoholics. The services of the private Institute, which enjoy high standing in the community, with the majority of agencies in the province, and with the departments of government mentioned, based on a reputation gained by treatment results, have been restricted recently by a lack of available funds.

In the view of the Committee, the operation of the Diversionary Project based on the Kent Street facility and the unopened farm at Fredericton, exemplifies the need for co-ordinated and thorough planning to precede program development. Although the project is not without merit, insofar as the utilization of expensive hospital beds has been reduced, and in that arrested public inebriates in the Charlottetown area have had the opportunity of admission to the Kent Street detoxification service, the full purpose of this development has not been fulfilled because, in the Committee's view, the necessary program philosophy and legislation are lacking.

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Alcoholic admissions to the new Correctional Centre in Sleepy Hollow have been sufficiently large in number to mock the original intent of excluding from that institution arrested public inebriates. The Kent Street facility has been neither willing nor able to detain uncooperative patients who are then referred to the county jail. Essentially, medical detoxification services, if they are necessary at all, seem no less required by the unruly inebriate than by the quiet one, but without Kent Street's assuming the authority of preparedness to detain for purposes of treatment, the consequences of this extra program has been simply to disseminate the "revolving door" phenomenon through yet another facility.

Although the Addiction Foundation does accept in small numbers alcoholics compulsorily admitted under the Mental Health Act, the authority to detain such patients has had to continue to reside in Hillsborough Hospital. The cumbersome admission procedures involved in getting patients to the Foundation, which require a nominal admission to Hillsborough Hospital, followed by transfer to the Addiction Foundation, are inconvenient in the extreme, and must appear to the public to be an example of the worst form of bureaucratic red tape.

Hitherto, through no fault of either side, the relationship of the independent Crown Corporation, the Addiction Foundation, to the political process,has been less than satisfactory, despite the presence on the board of four representatives of government departments, namely, Education, Health, Justice and Social Services. Government's wishes have not been clearly expressed to the board, and, reciprocally, the board's

advice to government can best be described as peremptory.

An atmosphere of irritation has, at times, occurred which has been both undesirable and unjustified. The Committee, however, regards this shortcoming as inherent to the present organizational structure and unlikely to be changed by elevating the departmental appointees of the board to the level of Deputy Minister. The occasionally conflicting interests, and the sometimes different theoretical orientations of respective human service departments of government, can lead to hindrance at the board level every bit as much as at the field level.

The Committee's survey of existing preventive services revealed that there were more activities of this type than were at first apparent; further, a consciousness of the importance of prevention is not lacking. Preventive efforts, however, suffer from the absence of clear allocation of responsibility for their initiation and coordination causing vacuums in some areas and duplication in others.

The gravest shortcoming of existing treatment services is the relative paucity of rehabilitative treatment in relation to detoxification services, implications of which are profound. The effects of the closing of the residential rehabilitation program within the Addiction Foundation in 1978, and the discontinuation of acceptance of compulsorily admitted alcoholics to it in 1975, have been conspicuous. The system, consisting of widely and readily available detoxification, limited rehabilitation, and minimal coercion, as has evolved in our province, is classically liberal. Such a system may conserve community safety and make alcoholism safer for its sufferers, but appears to the Committee to have too little to say about the treatment of a potentially recoverable condition.

The Committee cannot praise too highly the work of the staff of the detoxification centres, but considers them to have been severely handicapped in their attempts to provide intensive short-term rehabilitative treatment for several reasons: the average length of stay of 7 - 8 days is too brief considering that the alcoholic is frequently refractory to psychological interventions for several days after cessation of drinking; the professional skills and time needed for a comprehensive assessment and for interviewing and counselling the family members have not been employed although available; the rapid patient turnover involves much time in medical and nursing procedures.

The residential rehabilitation service to which patients might have been referred from the detoxification services for extended treatment is no longer in operation, and the present capacity for out-patient treatment of the Foundation's rehabilitation division is severely restricted. Since, in the Committee's view, the giving of a critical sufficiency of treatment is essential to significant treatment effects, the nature of the allocation of resources within the Foundation has led to a dubiously effective and incomplete system of services.

The causes of this situation are many. The difficulties faced by the Board in 1975 can hardly be over-estimated, commencing their work as they did in an atmosphere of bitterness and suspicion. Undoubtedly, the rational planning of new services, which were to be rapidly developed and accompanied by a substantial influx of funds, was impeded by strident community demands and political prompting. For example, the Addiction Foundation was compelled in the interests of fairness alone to develop detoxification services in each of the Island's counties. Similarly,

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the Diversionary Project was developed at the instigation of the Departments of Health and Justice rather than of the Addiction Foundation's own initiative. Once in place, the detoxification units experienced heavy demands for service, and the allocation of rehabilitation resources to other program components prevented reinstatement of a rehabilitation program.

The Committee holds that this fundamental organic flaw will, unless remedied, condemn further development to a perpetuation of the disproportion between the resources allocated to detoxification and rehabilitation: the nature of the non-medical professional representation at the locus of administrative power has led to an inadequate representation of the scientific viewpoint, and to the failure of professionals and traditional alcoholism treatment personnel to work in the same clinical setting.

The resignation of the Medical Director of the Foundation in 1974, and the sudden influx of non-medical professionals to the Foundation after 1975, led to an unnaturally abrupt separation of clinical and administrative power. The traditional alcoholism treatment organizational mode, involving the use of empirically-trained recovering alcoholic para-professionals, has evolved as a special case among clinical styles with unique characteristics, such as little differentiation between clinical and administrative functions, and a strict adherence to the tenets of A.A. and contrasts with the organization of professional treatment modes. The two modes are in

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some ways antithetical. In Prince Edward Island, the traditional modes predominate in the Alcohol and Drug Problems' Institute and in the detoxification centres of the Foundation.

The one professionally-operated residential program within the Foundation was closed for lack of referral and cannot be said to have been fully tested. As the Foundation has demonstrated the diffusive tendencies of all growing organizations, new levels of administration have emerged which have been occupied by professionals who have thus retained power while their clinical contribution has progressively diminished, producing a tension responsible, in the Committee's view, for the poor internal communications and examples of mutually-destructive strife to which the Boothroyd Report alluded. This tension and preoccupation is unlikely to recede until the non-medical professionals are able to work in the same clinical setting as traditional workers, a task admittedly requiring considerable sophistication.

The endless philosophical disputations surrounding alcoholism treatment services were felt by the Committee to merit close scrutiny. Locally, "philosophy" has become a much overworked word, and should probably be dropped. "Philosophies" have tended to serve as battle standards around which warring camps of allies have rallied. However, a philosophy in the sense of a treatment-faith there must be, and it would be unwise to step into a clinical setting without one. The

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scepticism engendered by scientific inquiry, however, is inappropriate to the treatment setting. Neglect of this rarely appreciated or attempted distinction has consequences leading to the abandonment of the neutrality needed for objective evaluation. The call by the Addiction Foundation Act for the concerted action of the different professional groups has foundered precisely because of the philosophical differences occurring across professional disciplinary lines.

Philosophical differences in the best sense of the word, however, have crucially and, in the Committee's view, detrimentally, influenced service development since 1975. The liberal-humanistic stance which the Committee believes to have held sway at the centre of administrative power within the Foundation, has led to the abandonment or, at least, the relegation to a position of minor importance, of the disease model of alcoholism, the implications of which have been major.

This liberal view holds man as evolved, self-determining, and capable of free choice, and thus responsible, and to be held to account for his actions. The existence of certain conditions such as good health, absence of poverty, and pertinent information, renders rational the individual's choice including, presumably, that concerning the use of alcohol.

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The mutual determination of the concepts of free agency and responsibility not only lead to a rejection of authority in the clinical setting as being ethically abhorrent, but make the exercise of clinical authority contradictory to the very process of treatment. In contrast, under the disease model, the alcoholic's disability lies precisely in his inability to choose whether or not to drink and he is viewed as a person in need of care or treatment. The ethical base of this model is unashamedly paternalistic, and would probably, in the extreme libertarian view, be characterized as predatory.

It is the view of the Committee that any approach to the treatment of alcoholism which purports to be scientifically grounded must utilize the hypothesis of determinism, i.e., the theory that human action is not free, but is determined by motives regarded as external forces acting on the will. The subjective nature of concepts such as free choice and responsibility are incapable of measurement and involve a value judgement which is prone to have detrimental effects in the clinical setting. Subtle effects occur, too, in matters of policy, examples being stringent motivational requirements for program entry, and the affording of favor to those seeking first rather than subsequent institutional admissions. Ultimately, non-deterministic models, in the Committee's view, can only serve to perpetuate the moralistic attitude towards the alcoholic which society has been in the process of abandoning in the past decade.

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To state as a matter of objective fact that the exercise of an authority of some type often plays a significant role in the alcoholic's recovery is not to promote any authoritarian ideology. In the traditional setting, the assignment of authority to clinician by patient, by mutual, if tacit, assent, reflects a social transaction of extreme value to treatment of alcoholics, where the temporary exertion of social control, the acceptability of confrontation, and the active engagement of a clinician on the patient's behalf, seem to the Committee crucial components of a successful treatment process.

The fact that less than 5 percent of the large numbers of patients admitted to the Addiction Foundation's detoxification centres subsequently entered the residential rehabilitation program is revealing in the extreme, and, in the Committee's view, explicable in terms of inappropriate views of motivation. In the case of addictions, the motivational forces for continued use of the substance of choice are invariably strong and often overcome only by severe physical and psychological discomfort. Thus, the reason for voluntary entry into a freely available detoxification service is likely to be little more in a majority of cases than the seeking of relief from this discomfort.

The job of treatment, in the Committee's opinion, is, by ethical means, to induce motivation in the addict for the achieving

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of abstinence. To those who equate treatment with punishment in these circumstances, it should be pointed out that the civil authorities, in the case of alcoholism, are actively engaged in the process of abandoning judicial punishment as useless. Programs developed on their assumption of a high degree of prior motivation in the alcoholic are, in the Committee's view, unrealistic.

Of serious import has been the Addiction Foundation's reluctance to accept the direct authority to detain, for purposes of treatment, the minority of alcoholics whose condition necessitates compulsory admission under the Mental Health Act, which the Committee believes, indeed hopes, to have been due to the Foundation's ethical stance. Were there no ethical justification for this reluctance, then such an attitude would have the appearance of transferring the most difficult and distasteful aspects of alcoholism and treatment to other agencies.

To have accepted such authority, in the Committee's view, would have been little more than a technical matter, with the implications for additional resources relatively minor. The continued reluctance to assume such authority by the principal provincial alcoholism treatment agency will continue to render impossible any serious attempt to decriminalize public inebriation. After acute psychiatric care is transferred from Hillsborough Hospital to the general hospitals (by 1981,

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it is hoped) the psychiatric units will quite simply be unable to accept compulsorily admitted alcoholics because of a significant reduction in the number of available beds. Controversy over this issue of compulsory admission, which has continued since 1975, has produced unusually divisive effects and ought to be settled quickly.

The truly liberal character of provincial alcoholism treatment services, to which the Committee has already alluded, and which it finds to be less than satisfactory, must continue for as long as the present philosophical premises prevail at the planning and decision-making level of the social institution established by government as the principal service provider. Until such time as the results of scientific inquiry can better clarify the nature of alcoholism, the latitude for philosophical disputation, and the corresponding struggles for professional advancement, which have been so costly to treatment services, are likely to be boundless. Regrettably, in the heated atmosphere which has surrounded services for alcoholics in the past several years, genuine philosophical differences are likely to render appeals for cooperative efforts, such as that expressed in the Addiction Foundation Act, ineffective for some time to come.

The Committee believes that government alone, by determined political decision, can resolve the issues that have been outlined.

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Finally, the Committee must re-emphasize the importance of evaluation and outcome studies. The mandate of the Addiction Foundation Act to conduct such studies has not been fulfilled, both because of the immense difficulties inherent to activities of this type, and, no doubt, because of lack of resources. The objective evidence that might have been obtained may possibly have settled much of the dissension over treatment method and outcome of the past few years. Whether such studies would have averted the budgetary constraints that have impaired the consolidation of the Foundation's rapidly expanded programs cannon be known, but the importance of evaluation, clearly stated in the Report of the Premier's Task Force, and recognized in the Addiction Foundation Act, cannot be over-estimated.

FUTURE DIRECTIONS

1. General Issues

Alcoholism is the price that society pays for its favoured intoxicant whose moderate use on appropriate occasions, however, is generally agreed to be harmless. In a stressful age, alcohol probably confers important and unrecognized benefits in increasing social cohesion while the economic and personal costs of alcoholism grow alarmingly. The adage that what is powerful for good is potent for harm most certainly holds true.

Action to counter the serious phenomenon of alcoholism and drug addictions must be taken not only by government but by many organizations, public and private, and by citizenry, if it is to be effective. There can be no panacea; only sustained and rational effort can succeed and, at that, slowly. In a free society, consisting of different groups adhering to different values, whose continuation as a unity depends precisely on divisions enabling those disagreeing on one issue to agree on another, the correct role of government can be determined only by sophistication of a high order.

The field of alcoholism is beset by conflicts of interest, including those within government itself, a bewildering farrago of different opinions, and attitudes both unjustifiably intense and indifferent. Fundamental ethical issues involving the liberty of the individual and the powers of the state arise. In the Committee's view, definitive choice and decision by government alone can bring about sufficient resolution to permit the co-operative action needed to reverse the trend of recent years, and our recommendations, the issue

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of lengthy deliberations, are intended to serve as a guide.

The Committee believes that the simple ethical premises that sobriety is preferable to inebriation, and that efforts to conserve life are worthwhile, should find common agreement. Since over 50 percent of identified alcoholics are reported to improve as a result of treatment, the funding by government of alcoholism treatment services seems justified on moral grounds alone. Whether treatment services can be justified in terms of cost-benefit is less obvious, but the working assumptions that alcoholism is a recoverable condition, and that the restoration of the alcoholic to a pre-morbid level of functioning is cost-beneficial do not appear to the Committee to be unreasonable.

The Committee, as did the Premier's Task Force, recommends to government the pragmatic advantages offered by the "disease model"* of alcoholism as providing clear courses of action in all segments of society to those involved in the problem. It acknowledges however, that over-simplified understandings of this model have led to disproportionate emphasis on treatment as opposed to prevention.

The Addiction Foundation in a brief to the Committee, drew its attention to the finding that the rate of alcoholism increases in proportion to any increase in per-capita consumption, implying the need for social measures designed to reduce average consumption. Preventive strategies, addressed in detail in a succeeding chapter, must, therefore, be recognized as having crucial importance, and must be seen to include direct action by government.

* See Appendix

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Although adequate treatment services will continue to be an essential component of any approach to combat alcoholism, their provision should not invite any abrogation of personal responsibility for the acceptable use of alcohol. The promotion of good health by what has come to be termed "lifestyle" education, which certainly pertains to drinking habits, is a development fully supported by the Committee, and expected to become increasingly emphasized.

Society's move towards the decriminalization of public inebriation, excepting those cases involving additional offenses, is one which the Committee wholeheartedly supports. Jail is an inappropriate setting for the management of a condition which involves medical risk. However, the implications for resources, were such a movement to become official, cannot be known without further detailed studies. Institutions instructed to receive, assess, and treat public inebriates will have to recognize the need for their assuming a temporary social control function if the present "revolving door" phenomenon is not to be perpetuated.

The Commitee believes that a rational, comprehensive, and effective system of treatment is possible in a small jurisdiction such as Prince Edward Island, but not without appropriate accompanying comprehensive legislation which defines categories of alcoholics, their rights, and the legal power of apprehension and detention for purposes of assessment and treatment.

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Recommendations aimed at providing comprehensive legislation are made below in the Chapter on Legal Issues.

The existing funding of services for addiction, greatly exceeding the budget of the Addiction Foundation alone, is perceived by the Committee to be adequate, but government is urged not to curtail this funding in any way.

RECOMMENDATION # 1

That the present level of funding of addiction services by government be maintained or increased.

In keeping with the policy recommended by the Report of the Premier's Task Force, the Committee recommends that services, where possible, be purchased from private bodies or agencies who have demonstrated the ability to deliver treatment or caring services of acceptable standards to the co-ordinating body.

RECOMMENDATION # 2

That services, where possible and feasible, be purchased from private bodies or agencies.

The Committee believes that such a policy would have the effect of avoiding duplication and diminishing rivalry.

Although the Committee deplores the emergence of multiple individualistic human service agencies prone to act independently, it anticipates that a need for separate specialized treatment services for alcoholism and drug addictions will continue for some time. While, eventually, the treatment of alcoholics may become incorporated

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satisfactorily into present general services such as Health and Social Services, factors such as professional attitude and the unique character of alcohol treatment programs render such a move impractical at present. The delivery of treatment services in the facilities of the Addiction Foundation and in the Alcohol and Drug Problems Institute is at present more economical than that in a general hospital setting. The subsequent recommendations of the Committee, however, are intended as a first step towards the general integration of human services which was a major theme of the Report of the Premier's Task Force.

11. Administrative Issues:

- The Role of the Addiction Foundation and Alternatives

The principal weaknesses of the present system of treatment services which the Committee have identified and documented: poor coordination, the failure to resolve the issue of compulsory admission, the separation of professional and traditional clinical modes, and, most significantly, the disproportionately large allocation of resources to detoxification, have all made difficult for the Addiction Foundation the fulfillment of its mandate with respect to rehabilitation, which, in the Committee's view, is precisely the area by which outcome should be judged.

The Committee is sceptical that an internal reorganization of the Foundation, or changes in policy, will necessarily remedy these weaknesses. The nature of this social institution, its relationship to government and other agencies, its possibly unrealistically broad mandate, suggest to the Committee irremedial organic flaws.

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Difficulties in the organizing of treatment services for alcoholics are universal, but in a small province with limited resources, such as Prince Edward Island, the need for efficient organization and coordination of service, and effective treatment service, becomes an imperative.

The Committee proposes a major organizational change which it believes will have the advantages of reducing administrative costs, increasing the effectiveness of treatment services, improving the coordination of services, and ameliorating the atmosphere of debilitating dissension which has surrounded services to date.

The Committee believes that the clinical mode of alcoholism treatment which, provincially at least, has evolved in a unique form and which fully incorporates the organization Alcoholics Anonymous as the backbone of its system of rehabilitation thus drawing heavily on the local community's resources, would better thrive with greater autonomy than can be permitted under a system of central management. The economic, clinical, and political advantages of a decentralization of management function appear to the Committee obvious.

RECOMMENDATION # 3

That the Community Hospital Boards assume regional management responsibilities for the facilities and programs now administered in Summerside, Charlottetown and Souris by the Addiction Foundation, in accord with the principle of decentralization of management. However, this does not restrict future involvement of other Community Hospital Boards.

RECOMMENDATION # 4

That the boards of these hospitals appoint Addiction Advisory Committees, of professional and non-professional community members.

There does not appear to the Committee to be cause for any assumption that the cost of services in facilities administered by hospital boards is likely to increase, since the present staffing ratios and standards of practice in the facilities of the Addiction Foundation appear to be entirely satisfactory as they apply to detoxification and limited rehabilitation.

To better achieve a well coordinated, effective and comprehensive system of treatment for alcoholics, which is uniformly accessible across the province, and whose quality of care is even, in addition to the decentralization of management function to the community hospital boards, government should, in the Committee's view, move the control of services more central to itself by the ultimate expedient of the use of conditional provision of funding for specifically mandated services. The responsibility for planning, coordination, standard-setting, and quality control, thereby, will fall more directly within government's ambit, releasing the service providers from duties, which in the present system of organization, they inevitably have had to assume.

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It is the Committee's belief that this type of separation of administrative and clinical duties will bring about an increase in the effectiveness of treatment services. The service organizations will continue to provide detoxification, rehabilitation, and care of the chronic impaired alcoholic, and continue with the responsibility for applied research and evaluation. It is the Committee's belief that the non-medical and nursing professionals would be released from administrative responsibility and enabled to apply their valued clinical skills in a treatment setting. The regionally-based service providers would receive a global budget from the central funding authority, not only for service provision, but for education and staff training, community development, research, and evaluation.

Careful consideration during the course of lengthy Committee deliberations was given to the most suitable form of a central funding, coordinating, and standard-setting body. Three options were identified, their individual advantages and disadvantages were assessed, and a recommended course of action was put forward. The following summarizes this process:

Option #1

It was suggested that the Hospital Services Commission could expand its mandate to include addiction services. This pattern has many of the same advantages as a separate Commission. The Hospital Services Commission, at present, carries out similar functions; it has staff available, it already acts as a buffer between government, the professionals, and service providers, it has existing regulatory power which could be expanded to the alcoholism

field without a significant legislative change, and it can carry out the identified functions at the least cost. In addition, the Commissions' expertise in quality control could be built upon to assess clinical performance. They have a sophisticated budgetary system with staff, and have been directly involved in consulting and providing guidance and assistance to hospital boards. There is a very real potential for economic savings in the administrative area.

The Commissions' present involvement with hospital boards also augurs well for their assuming functions which will ultimately interface with the hospital boards of the region. Finally, since one of the intents of the report is to open the way to an eventual integration of health and alcoholic programs, it would seem apparent that an organization now charged with this responsibility should carry it out.

However, there are disadvantages to this approach which should not be ignored but should be guarded against. For example, there is a danger that the alcohol treatment field will lose its primary focus, and staffs of the Commissions may not devote an appropriate amount of time to this area. Therefore, the Commissions must recognize the magnitude of this activity so that sufficient efforts are made to insure that the proposed system can be implemented. There may be additional staff requirements, for example, in the area of policy development and assessment. However, with only minor modifications and a small increase in staff, the Commissions should be able

to carry out the functions as described in the report. For these reasons, this option is recommended by the Committee.

Option #2

It was suggested that treatment and rehabilitation of alcoholics become a responsibility of a division within a government department. This approach increases the amount of direct government control and allows greater coordination between government departments and agencies. This approach recognizes a governmental responsibility for overall direction of policy in this area and may encourage the use of other government resources such as consultants and educational specialists. However, this would become a significant new function requiring an increase in staff and a significant increase in costs. The structure and slow-moving process of government may also preclude rapid decision-making. The egocentrism and inability to coordinate which now exists between certain government departments does not add support to this approach. Finally, and importantly, many professionals and the public alike have exhibited a distaste for increasing direct government involvement in the provision of medical services. Therefore, this pattern is not recommended.

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Option #3

It was suggested that the role of the Addiction Foundation could be altered so that it becomes an Addiction Commission. This model has the advantage that a major socio/medical problem has the full attention and special commitment of a separate commission, that such a specialized commission would have the overall field in view and could make informed policy decisions, that a commission could identify gaps in a system and encourage service development to fill these gaps, that a commission could act both as a buffer between service providers and as an advocate for change in the system, and that such a commission could provide public accountability for decisions taken. However, more than offsetting these advantages is the fact that there would be considerable difficulty in changing the Addiction Foundation's mandate so radically. The potential to assume a primary role as co-ordinator, consultant, while dropping direct service provision and capitalizing on private and volunteer sector involvement seems highly unlikely. Major philosophical and program changes would be required to further achieve the desired integration with others in the health sector. There is also the problem that addictions' commissions have not exhibited a significant degree of success, nor is it likely that the public will sanction their proliferation. Therefore, this pattern is not recommended.

In summary, the obvious similarity between the objects of a central funding, coordinating, and standards-setting mechanism for the treatment of alcoholics, and the existing role and function of the Hospital Services Commission, indicates that the Commission's mandate should expand to include the alcohol treatment field. The Commission, at present in the area of in-patient and out-patient hospital care, is involved in a determination of the provision of an appropriate level of services. To achieve and maintain quality service, the Commission monitors staffing levels, budgets, and equipment, encourages staff development and training both within and outside the province, establishes and maintains standards of performance consistent with high quality patient care, and is committed to the assurance of the provision of quality service in general under the aegis of the Hospitals Act and its Regulations. The Commission carries out its functions through the medium of dialogue and discussion between individual hospitals and the staff consultants in the areas of Standards, Administration, Nursing and Dietary.

Similarly, the Health Services Commission, through the Medical Advisory Committee, encourages the maintenance of high quality physician services in the province. Due to the unique aspects of addiction treatment services, it is also proposed that an expert consultant be added to the staff of the Hospital Services Commission, to assure a knowledgeable presence in the field and to provide continuing assistance and direction to service providers and alcoholics and their families.

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RECOMMENDATION # 5

That the Hospital Services Commission become the central, co-ordinating, standards-setting, and funding body for addiction services in Prince Edward Island.

RECOMMENDATION # 6

That an expert consultant be added to the staff of the Hospital Services Commission.

The Committee is fully mindful of the difficulties inherent in, and the political implications of, the dissolution of any social institution once established. Essentially our recommendations, if acted upon, preserve the facilities, staff, and programs of the Addiction Foundation, simply placing them into an alternative organizational setting, which, in the Committee's view, is more likely to be productive of effective service and coordination.

The Committee finds no reason to assume that its suggestions for reorganization imply any loss of employment, although it is possible that some of the present staff of the Foundation may come in future to be required to work in different settings to their present one. It is the Committee's belief that each regional system of alcoholism service located in the three counties of Prince Edward Island can collectively assume the greater part of the present mandate of the Addiction Foundation.

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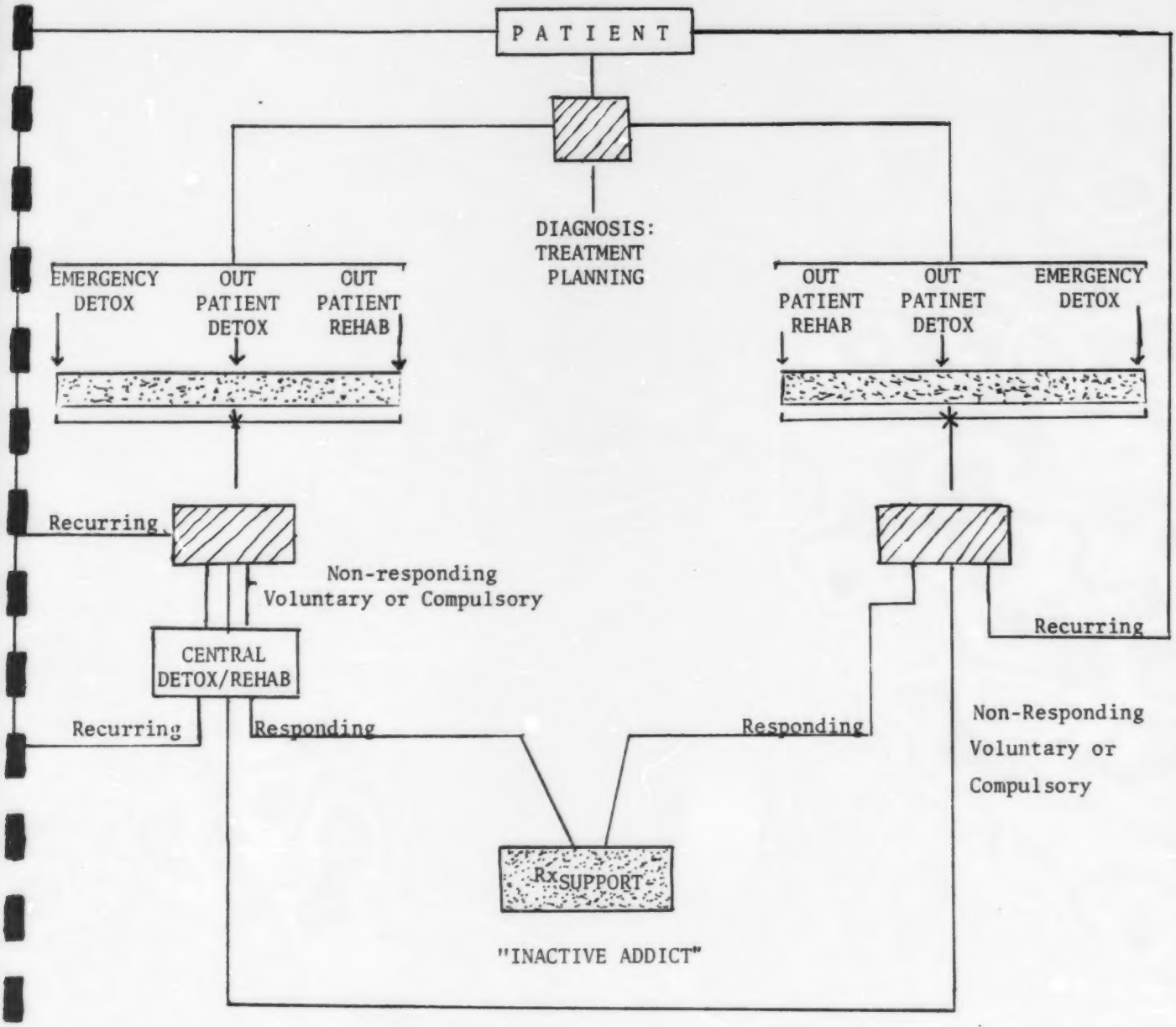
DIAGRAM "A"



Legend:

- MEDICAL/NURSE, Placement, Initial Assessment

- MULTI-DISCIPLINARY & VOLUNTARY TEAM (SERVICES & SUPPORT)

111. Treatment Issues:

- Components of a Comprehensive System of Addiction Services

a) Facilities and Programs:

It is the view of the Committee that, at the time of writing this report, the facilities which are at present in use are adequate in form and number for the satisfactory operation of an effective and comprehensive service system for alcoholics. The Committee, however, has learned that the central building at present occupied on University Avenue in Charlottetown may soon need to be vacated.

RECOMMENDATION # 7

> That the facilities in Summerside, and Souris continue to be the location of active in-patient detoxification services, and out-patient rehabilitation and after-care, and, should their management be assumed by the community hospital boards, that each become known as a county Alcoholism and Drug Addiction Treatment Centre (ADATC), a title which should help to dispel their identification as simple detoxification units.

The introduction of assessment and referral procedures, and an adjustment in the allocation of resources, will, in the Committee's view, enable the ADATCs to expand considerably their existing programs at little extra cost, thus increasing their rehabilitation capacity. Paradoxically, the ready availability of in-patient medical detoxification studies reduces the need, at least in a medical sense, for procedures of this type. Recent research has indicated that only a small minority of individuals entering

detoxification units develop severe or dangerous withdrawal effects which necessitate medical intervention.

Particularly in light of the fact that less than 15 percent of admissions to provincial detoxification centres come from physician referral, the Committee concludes that many admissions are on social grounds, and that a medical/nursing screening prior to admission might pre-empt several unnecessary admissions and save resources. Such an assessment and referral, however, must be accompanied by emergency community support services as might be offered by government and voluntary resources.

Further, the ADATC must develop an out-patient detoxification service often involving daily attendance or home visiting. Out-patient detoxification services are in the process of development in many jurisdictions in North America, and that locally operated by the Alcohol and Drug Problems Institute could usefully serve as a model for the ADATCs.

RECOMMENDATION # 8

That the ADATCs introduce a system of medical/nursing screening for all cases prior to admission. This should be available on a 24-hour basis.

RECOMMENDATION # 9

That the ADATCs develop close links with the local government service office of the Department of Social Services, and with volunteer bodies, for the provision of emergency social relief for alcoholics and their families.

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RECOMMENDATION # 10

That the ADATCs develop out-patient detoxification services.

While the need for in-patient detoxification will continue, an out-patient detoxification service should make possible a reduction in the number of beds, and we urge that ADATCs make strenuous efforts to this end. In view of the growing incidence and identification of alcoholism in women, it is recommended that in-patient units develop separate areas within the facility for the use of women. The absence of separate areas may, in the Committee's view, serve as a disincentive to program entry for women whose reluctance to enter treatment is already well known and whose acute alcoholism renders the preservation of modesty problematical.

The Committee argues for the need of ADATCs to accept authority to detain compulsorily admitted patients. The additional resources needed are not expected to prove significant, particularly if there is a volunteer body working with the unit. In alcoholism the period of violence, if it occurs, is generally brief. Seclusion rooms and the employment of male attendants should suffice for cases such as this.

RECOMMENDATION # II

That ADATCs make efforts to reduce the number of beds available for detoxification.

RECOMMENDATION # 12

That separate areas for the use of women patients be developed within the in-patient facilities.

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RECOMMENDATION # 13

That ADATCs accept the authority to detain compulsorily admitted patients under the terms of proposed legislation.

Treatment of the recoverable alcoholic must be seen as a continuity commencing with case identification, passing through the process of detoxification to entry into a specific rehabilitation program which may take various forms. Because alcoholism by its nature tends to be a protracted condition characterized by episodic relapse with improvement frequently gradual, a prolonged system of after-care is often necessary for a period of seldom less than two years.

Progression through treatment must be founded on what the Committee considers to be a crucial component that has to date been regrettably lacking, namely, the process of comprehensive assessment which should usually involve members of the alcoholics' family. Failure to fully assess may lead to unrealistic case-planning, failure to refer, and to an inappropriate use of resources. A full assessment, some aspects of which are not possible during the early stages of detoxification, should be made in every case, and will often involve the contribution of more than one professional discipline. Assessment can be adequately carried out in both an in-patient and out-patient setting.

RECOMMENDATION # 14

That ADATCs acquire a capacity for comprehensive assessment.

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The Committee recommends that ADATCs develop intensive out-patient rehabilitation programs of up to 6 weeks modelled on that provided by the Alcohol and Drug Problems Institute which includes didactic teaching, discussion, and group and individual therapy. This may involve the patient's daily attendance at the out-patient facilities for periods of several hours, possibly during the evening for those employed, as suggested by the Ontario Task Force.

Although to some extent biased by a pre-selection of patient characteristics, studies comparing in-patient and out-patient rehabilitation programs have not shown any superiority in outcome of the treatment given in the more expensive in-patient setting.

RECOMMENDATION # 15

That ADATCs develop intensive out-patient rehabilitation programs.

A range of linking after-care services should be developed. The patient may be referred back to a community resource such as his primary physician, or Alcoholics Anonymous, or, when appropriate, discharged outright. The ADATCs should, however, develop their own after-care service for patients and their families which may take the form of out-patient attendance or visits by staff members to the patients' homes.

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RECOMMENDATION # 16

That ADATCs develop a system of after-care.

In summary, the county ADATCs should develop the capacity to provide emergency medical/nursing screening, comprehensive assessment, in-patient and out-patient detoxification, out-patient rehabilitation, family support, counselling, and after-care. The provincial co-ordinating body should, without delay, draw up by-laws, rules and regulations specific to alcoholism services, which, the Committee hopes, would leave the way clear to open-admission policies for physicians to the in-patient units. The Committee believes that the proximity to, and inclusion in, alcoholism treatment services of family physicians, who, in 90 percent of cases represent the first community resource to whom the alcoholic turns, will lead to a greater awareness of alcoholism and earlier recognition; moreover, that this development would be a significant step towards the integration of health and alcoholism services.

RECOMMENDATION # 17

That without delay the provincial co-ordinating body develop by-laws, rules, treatment guidelines, and regulations for the ADATCs, and that, thereafter, open-admission policies for physicians be considered.

There remains a significant number of recoverable alcoholics for whom a sustained period of separation from their usual circumstances is essential to recovery. Annually, several Islanders with alcoholism are sent for treatment in specialized institutions with residential rehabilitation programs whose average length of stay is 30 days. The outcome of these programs, as locally experienced,

has been highly encouraging. This form of service, however, is at present only available to those who can afford the cost of travel.

The Committee, therefore, recommends the establishment of a residential day-care rehabilitation facility and program of the type that existed within the Addiction Foundation until 1975, with a capacity of 30 - 40 beds. Such a facility should, in addition to voluntary admissions, accept the authority to detain for purposes of treatment, alcoholics who have been compulsorily admitted. It should be located centrally in Queen's County and serve as a provincial, rather than regional resource.

It has been in Queen's County that the coexistence of private and government services has led to rivalry, and, possibly, to duplication of service, which the Committee would wish to see eliminated in the future. Since it is understood that the Addiction Foundation's present facilities in Charlottetown are to be vacated, there is uncertainty in the Committee's mind as to a particular recommendation respecting future facilities. Since the Committee has already enunciated the principle of the desirability of government agencies' contracting for services from private bodies, we would recommend the contracting out of the residential rehabilitation program.

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RECOMMENDATION # 18

That government support the contracting out of residential and day-care rehabilitation facilities in Queen's County as a provincial resource.

While it is often said that a range of treatment modalities is necessary for the treatment of alcoholism, without knowledge of the characteristics and proportions of the groups of alcoholics who respond to a given treatment method, development on this assumption may prove costly. On utilitarian grounds, the Committee would suggest that service providers develop standard treatment guidelines. A variety of therapies are already available in the several extant human service agencies to which patients may be referred, if indicated as appropriate, by the assessment process.

Should the policy of decentralizing management and increasing regional authority be adopted, the Committee would strongly recommend to Government that treatment services be encouraged to establish links for purposes of education, evaluation and research, with an approved centre of excellence such as the Donwood Institute in Toronto.

RECOMMENDATION # 19

That Government encourage an association between ADATCs and an approved centre of excellence such as Donwood.

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For the severely affected alcoholic whose community support system has broken down, and for those alcoholics suffering from a degree of permanent impairment, intermediate or long-term care stay in the county half-way houses has proved invaluable. The Committee regards the existing half-way houses as integral components of any comprehensive system of service whose operation could conceivably be expanded, space within the facilities permitting.

RECOMMENDATION # 20

That community hospital boards assume management for half-way houses.

The care of severely impaired and apparently irrecoverable alcoholics who are not residents of long-stay institutions, such as psychiatric hospitals, poses immense difficulties. Traditionally, the care of these persons has been undertaken by religious and charitable bodies such as the Salvation Army, and locally, the Catholic Family Service Bureau. We recommend to government that it support private initiatives to establish hostels to care for this group.

RECOMMENDATION # 21

That government support private initiatives to establish hostels for indigent alcoholics.

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b) Personnel

Physicians, nurses, and nursing attendants are clearly essential in any treatment setting that involves medical detoxification procedures. In the range of treatment services intended by the recommendations of this Report, all of the non-medical helping professions, including psychology, social work, and occupational therapy, appear to the Committee to have a valued and necessary place, particularly in the areas of assessment, and counselling and psychotherapy for the alcoholic and his family members. The Committee acknowledges the difficulties for professionals working in the traditional alcoholism treatment setting, but hopes that these difficulties may be overcome by those who have a definite calling to work with alcoholics, and must re-emphasize the importance of avoiding the clinical separation of professional and traditional workers.

The Committee strongly recommends the employment in treatment services of recovering alcoholics in significant numbers. The advantage of the use of empirically-trained, recovering alcoholic para-professionals is twofold; first, the Committee believes that this policy serves the interest of economy; second, the exposure of the alcoholic to workers of this type, drawing enthusiasm from their own recovery, appears to the Committee to have strong motivating effects.

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In employing people to provide this service, it is necessary to begin with a person who is empathetic rather than sympathetic to the patient and his situation. This individual must be able to guide rather than push, and perhaps above all, be able to demonstrate, through his own personality, that what he suggests can be accomplished.

RECOMMENDATION #22

That recovering alcoholic para-professionals be employed in significant numbers in alcoholism treatment services.

c) Community Resources

Community resources, including private, government, and voluntary bodies and agencies, are components fundamental to any comprehensive alcoholism treatment system. The several dimensions of the problems experienced by alcoholics invariably necessitate the involvement of services other than those provided by the specifically mandated alcoholism treatment services. It is the Committee's hope that the regionalized service delivery proposed in this Report will facilitate the coordination of the operations of the various human service agencies. Formal and friendly links between the various bodies should lead to a greater awareness of the nature and incidence of alcoholism, earlier identification, and more appropriate referral.

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The alcoholism treatment centres must assume a responsibility for making their services known and readily available, and must provide educational and professional services to community resources. The value of effective training programs for the staffs of the human service agencies is obvious. The assistance given hitherto by the Addiction Foundation to the native alcoholism programs of the province must be continued.

In this Report the Committee has alluded to the immense volunteer potential that would seem to be a consequence of the decentralization of management for services for alcoholics. Although Alcoholics Anonymous cannot be officially affiliated with any treatment service, the opportunities for an informal integration seem real; no less so for A.A.'s cousin organizations, Alanon and Alateen. The economic advantages of incorporating A.A. into treatment programs are clearly major. The effectiveness of A.A. as a system of rehabilitation for a condition that is by no means easy to treat is, in the Committee's view, based on a unique social support system which spreads throughout the community which is comprised of the A.A. membership. Although it is sometimes said that not every alcoholic is suited to the methods of A.A., the Committee is doubtful that this statement can apply to other than a minority. However, as already stated, alternative methods of treatment exist in several other human service agencies.

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The community mental health services of the Department of Health have, in the Committee's view, much to offer the treatment service system for alcoholics. The Committee would recommend that alcoholism treatment services develop formal contractual links with the Division of Mental Health to obtain consultation services, assistance with assessment, and treatment for family members.

RECOMMENDATION #23

That the Alcohol and Drug Addiction Treatment Centres provide effective training programs in alcoholism to the workers in community agencies.

RECOMMENDATION #24

That the Alcohol and Drug Addiction Treatment Centres develop formal contractual links with the Community Mental Health Service Branch of the Division of Mental Health.

d) The Role of General and Psychiatric Hospitals

The Committee would regard the general wards of community hospitals, as opposed to the discrete detoxification units which are to be administered in common, as an inappropriate setting for the simple detoxification of the alcoholic, both because the services of the general hospital are more expensive than those of alcoholism detoxification units, and because general hospital wards are ill-equipped to cope with the

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occasional patient who becomes disturbed or unruly during detoxification, when effects detrimental to the care of other non-alcoholic patients may be expected to result. However, general hospitals' beds should continue to be freely available to any alcoholic whose condition requires the investigation and treatment that can only be provided in a setting of this type.

The Committee in this Report has alluded already to the effects of the moving of psychiatric units into general hospitals. The reduced number of available beds will make it impossible for psychiatric services to admit those alcoholics who have been compulsorily admitted under the Mental Health Act for simple alcoholism. The Committee, though, would view admissions to psychiatric units of addicts suffering from associated, or coincidental, mental illness, such as Korsakoff's psychosis, alcoholic hallucinosis, alcoholic paranoia, severe affective illness, and some variants of organic brain syndrome, as entirely legitimate and appropriate to the function of a psychiatric unit.

e) The Diversionary Project

This program consisting of the detoxification units on Kent Street in Charlottetown, and the farm unit in Fredericton,

which has failed to open due to costs and unresolved issues, appears to the Committee to be excellent in conception but less satisfactory in practice. Designed to reduce jail admissions and to provide a system of care for the chronic alcoholic recidivist, who generates disproportionate cost to all human service agencies, it has fallen short because of the absence of authority to detain for assessment and treatment. Were the farm, which the Committee views as an imaginative and appropriate setting for the care of some chronic alcoholics, to be opened, there would appear to be no clear basis for the authority to have returned the inevitable absconder.

The Committee considers that more detailed study is needed to evaluate the merits of this program and to decide whether or not the funds involved would be better allocated to other areas. In the continuing absence of authority to detain for treatment, the correctional services must be prepared to continue to admit to its institutions the arrested public inebriate.

RECOMMENDATION #25

That the Diversionary Project be subject to immediate evaluation by the co-ordinating authority.

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f) Research and Evaluation

Both the Report of the Premier's Task Force of 1969 and the Report of the Mental Health Advisory Committee of 1978, gave full emphasis to the importance of the evaluation of the effectiveness of treatment. At no time is the evaluation of treatment results easy, but for alcoholism, the difficulties are immense. Nonetheless, the importance to a comprehensive system of addiction treatment services of evaluation cannot be over-estimated.

RECOMMENDATION #26

That evaluation be incorporated at the outset into every developing program.

It appears to the Committee unlikely that adequate evaluation can be performed without the assistance of other centres, and the linkages, to which the Committee has already alluded, with institutes such as Donwood, are recommended. In inflationary times, when human services are vulnerable to budgetary restraint and cuts, programs founded on careful evaluation must surely offer the best insurance for a continuation of full service.

In the field of human services at least, a clear lesson has been learned that research findings from elsewhere should be

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transposed only with caution to this province with its unique characteristics. The opportunities offered to original research in a small province such as ours, are very real. We therefore recommend that Government support any locally-undertaken research initiatives.

RECOMMENDATION #27

> That the central co-ordinating body seek assistance from centres of excellence with the development of evaluation.

IV. Prevention Issues

Since alcoholism has been designated by this Committee as a disease, some amplification with regard to how that definition relates to the concept of alcoholism prevention, particularly early prevention, is merited. In this regard, it is worthy to initiate the discussion on prevention by stating that it is entirely consistent, within the concept of the disease model, to view the onset of any particular disease as resulting from a number of interrelated factors, of which the physiological are, though extremely important, only a part. So it is with the disease of alcoholism. Social, mental and spiritual factors all must interact with the physiological factors resulting from exposure to the drug itself, for the disease of alcoholism to manifest itself.

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It is also of importance to realize that the onset of disease is not necessarily the point at which a full physiological display of the symptoms becomes apparent. In fact, the complex interaction of all the factors involved make it difficult at times to define the specific onset of the disease at all, although there may be no difficulty in accurately diagnosing a sufficiently developed case. This, again, is true for the disease of alcoholism. It is the interaction of all the factors involved over a considerable period of time that results in the diagnosable condition defined as alcoholism. It is entirely conceivable that a number of the predisposing factors may well have been at work long before the introduction of the drug itself.

Alcoholism, then, for the purpose of prevention, can be regarded as a progressive disease dependent upon the interaction of various factors, acting both before and after exposure to alcohol, which render the individual increasingly less capable of self-determined functioning such that at some point he can no longer be considered capable of managing his own life, and should ideally come under treatment for recovery.

Treatment in this context is easily understood as intervention in the progress of alcoholism at a point after the disease has manifested itself in a clearly diagnosable fashion. Treatment, then, functions from the well-founded assumption that most patients, by themselves, are unlikely to independently effect their own recovery.

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The Committee would not wish to see propagated an assumption that the adoption of the disease model gives sanction to any abrogation of personal responsibility. The "sick role" which society ascribes to the ill, confers not only the privileges of exemption from normal social duties during acute phases, and from blame for having contracted the disease originally, but also clearly defines obligations, including the duty to cooperate with treatment and to seek education about the disease, and an on-going obligation to behave towards himself and society in a responsible manner.

Within the same framework, prevention is intervention that occurs early in the progression of the disease at a point where, presumably, the individual, at least to some degree, can affect the interaction of predisposing factors in such a way as to interrupt the progression towards manifestation of the disease. Viewed in this manner, the interrelationship between prevention and treatment can be clearly seen. The difference between the two,centres around the point at which each intervenes in the progression of the disease and the resulting character of their respective application.

From a scrutiny of the briefs submitted to this Committee, it is apparent that generally there was a strong suggestion that more time and money be spent toward the prevention of alcoholism and its related problems. The concept of prevention intended by

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the briefs was not specifically defined although the examples given related mainly to the concept of early intervention or "primary prevention" (as defined by the World Health Organization): action "aimed at ensuring that a disorder, process or problem will not occur." The emphasis of the submitted briefs centered mainly in the area of education at the public school level and general education of the community at large.

This Committee is in full support of an increased emphasis upon early prevention programming through education.

Rationale for an emphasis on early educational prevention derives from an understanding of the implications of the progressive character of alcoholism. As the disease progresses, the individual becomes less and less capable of responsibly dealing with relevant information and applying it effectively to his own situation. Therefore, the earlier the intervention, the greater the utilizing capacity of the individual. Although necessary components of an overall prevention policy, preventive intervention at a later stage necessitates an increased intensity of programming due to the decreasing control those affected have over their own lives.

Early educational prevention programming is generally designed to cover total populations whether it be a school grade or all employees at a particular industry. The Committee feels that, wherever possible, such programs should be directed to high-risk groups. Public education is seen to serve an unselected

group; such education has been criticized as being costly since only approximately ten percent of most drinking populations ever become alcoholics and up to twenty percent of legal drinking aged Canadians do not drink at all. If this method of calculation is correct, this would give us an alcoholic population on Prince Edward Island much higher than that estimated for the province under the Jellinek formula, and further reveal the magnitude of the problem.

In addition, there has not as yet been any reliable test that can predict which particular individuals will start to drink or of those who start, who will develop alcoholism. From this perspective alone, until such testing can be accomplished, it is of great advantage, considering the economic, social and psychological cost to those who become victims of alcoholism before treatment is initiated, to utilize the concept of early prevention programming.

The Committee wishes also to emphasize that appropriate prevention measures such as employee addiction programs and family counselling, are valid and necessary in dealing with the middle and late states of the development of alcoholism, and should be included in a comprehensive approach to alcoholism services. Intervention is necessary at many points for adequate control of the disease.

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Despite the importance of prevention in the whole concept of alcohol services, the Committee believes that, in the past, emphasis by government has consistently been placed upon treatment aspects of alcoholism services in Prince Edward Island to the extent that an imbalance of approach has resulted. In addition, due, possibly in large part, to the strong visability of treatment services, in comparison with the inherent difficulties of prevention programming to generate statistically demonstrable results so attractive to the policy makers, there has been a concomitant imbalance in the relative distribution of funds.

The Committee feels it is important, therefore, that government emphasize and similarly support prevention programming in such a way that the policy adequately reflects the importance of both prevention and treatment in dealing with addictions.

RECOMMENDATION #28

That there be an increased emphasis on and support for prevention aspects of addiction services.

Because of the costs involved, it is understood by this Committee that treatment will continue to receive the largest allocation of dollars spent in alcoholism services. Costs for treatment programs are and will remain greater than for prevention

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services. In consequence, government has assumed that the community was responsible for supplying the bulk of prevention funding and services through the private sector and volunteers, both agencies and individuals. Understandable though this orientation may have been, it has resulted in a largely uncoordinated and limited approach to both prevention programming and resources. From the Committee's view, in order to increase the potential of prevention services to an appropriate level, a new balance needs to be created, one in which government would take on an increasing responsibility in the coordination, development, and funding of prevention services

RECOMMENDATION #29

That the major thrust in addiction prevention services be composed, in order of priority, of:

(a) Comprehensive addiction education for young people through the public school system;

(b) Public awareness through media;

(c) Available education programs for demonstrably at-risk groups such as children of alcoholics and residents of senior citizens' homes.

Education is a basic and necessary component of any comprehensive prevention program. As already noted, many factors

are involved in the progression towards alcoholism. An effective prevention program must influence as many of those factors as possible in such a way as to make alcoholism less likely to occur in a given individual.

It is granted that the number of factors involved in the development of alcoholism and the complexity of their interrelationships make it a difficult task to enunicate a clear causal pattern upon which to establish preventive measures. It remains possible, however, in a deductive fashion to draw valid conclusions regarding some general directions which, if followed, can be helpful in preventing individuals from developing the disease of alcoholism.

Substantial evidence confirms that peer pressure has a strong influence on the drinking and other social patterns of the individual. In the absence of a strong self-image, a person is likely to follow whatever pattern of behavior is the norm for the group he regards as significant.

It is also the case that a lack of information and a lack of skills in utilizing that information in a meaningful manner jeopardizes an individual's potential for making responsible decisions. As a result, decisions made tend to be self-defeating and irresponsible. Applying this to alcohol and other drugs, such deficiencies may well lead to patterns of use that result in increased dependence.

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Given its present accessability and acceptance, it is only by understanding and dealing with alcohol use as it relates to oneself that the individual can hope to avoid the possibility of unintentional drug dependence.

Finally, if in an individual's particular situation, he perceives that there are no alternatives open to him other than alcohol-related activities and friendships, the likelihood of his developing other options is small and, conversely, his chances of moving toward alcohol dependence increase.

It is this Committee's view that an educational program that provides accurate information on alcohol and alcoholism and other drugs, a useful means of utilizing available information in a decision-making framework, and appropriate alternative activities, is the most meaningful method of basic early prevention and can positively affect many of the factors we perceive to be ultimately linked with the development of addiction.

Preventive education should start in the home at the earliest age. It can then be effectively strengthened and elaborated upon through well-planned, comprehensive school programs, and followed into adulthood by continued community exposure to appropriate information.

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RECOMMENDATION #30

That prevention programming focus on:

(a) Education in the area of making reasonable, mature, and responsible decisions regarding alcohol and drug use;

(b) The development and availability of meaningful lifestyle alternatives not contingent upon alcohol or drug dependence;

(c) Growth in the knowledge and acceptance of one's strengths and capabilities.

Imperative to such an approach is an emphasis on: learning pertinent information regarding alcohol and other drugs; understanding how decisions are made, including the role of one's value systems; the knowledge and understanding of viable alternatives to drug-dependent lifestyles; and, a supporting environment for self-exploration.

RECOMMENDATION #31

That all prevention programming be consistent with the general principle that good health is preferable to poor health. Further, no particular religious, political, or racial prejudice should be promoted by any program offered, and no individuals delivering any prevention program should themselves be misusing the substance or substances in question.

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It is true that much of a young person's time is spent in the public school system and that the school's effect upon values formation is substantial. As a result, the classroom and co-curricular programs may prove to be a fruitful ground for alcohol and drug education. However, consistency of approach, maintenance of quality, and safeguards against saturation are all necessary for the success of a meaningful prevention program and therefore require coordination by a knowledgeable body. Since the prevention approach recommended by this Committee is basically an educational one largely utilizing the existing education structure for its implementation; and since the Department of Education has demonstrated a proven capability, the Committee recommends:

RECOMMENDATION #32

That full responsibility for the coordination of alcoholism prevention programming directed toward the school population, and the provision of addiction materials to school groups, be placed upon the pertinent divisions of the Provincial Department of Education, in co-operation with the central co-ordinating body responsible for addiction services.

RECOMMENDATION #33

That responsibility for community prevention programs not aimed at the school population should lie with the funding and co-ordinating body for addiction services, the delegation of programs being made to appropriate agencies or departments.

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A major extension of the educational process of prevention is on-going public awareness of alcohol and its effects upon society. In particular, this Committee decries the constant bombardment by the media to the effect that association with alcohol is not only acceptable but is a desirable lifestyle, consonant with good living and without negative consequences. Particular attention can be called to alcohol advertising associated with sporting and athletic events. This blatant form of biased advertising is in strong contradiction to the recommended approach and goals of alcohol prevention.

The Committee wishes to commend government for its position in banning lifestyle-linked alcohol advertising from network TV, and urges that it move to do the same on Cable TV. It is felt further that a program of counter-advertising should be run, emphasizing the benefits of a positive lifestyle without the use of alcohol and drugs.

RECOMMENDATION #34

That government make every effort to have advertising of alcoholic beverages banned from Cable TV.

RECOMMENDATION #35

That a program of counter-advertising be supported by government, linking positive lifestyles with alcohol-free and drug-free living.

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The Committee discussed the possibility of a monitoring mechanism being put in place in order to assist in the control of the use of drugs of an addictive potential. It was felt by the Committee that such a system could be run in co-operation with the Medical and Pharmaceutical professions and with the appropriate provincial and federal authorities.

RECOMMENDATION #36

That a surveillance system be organized by government to monitor the abuse of drugs of addictive potential obtained by prescription or through false or misleading information.

RECOMMENDATION #37

That the co-ordinating and directing body, direct attention to supporting family units where addiction is a problem.

In summary, the Committee wishes to emphasize that prevention is an integral and important aspect of the whole area of alcoholism. It is basically an on-going educational process dealing with knowledge, values, self-concept, and alternatives, which must be initiated early within the home, actively engaged in throughout the school years, and consistently supported by appropriate measures and continuing public awareness efforts. Should the above recommendations be adopted, it is the belief of this Committee that this will have a meaningful effect upon the curtailment of alcoholism.

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V. Legal Issues:

- Comprehensive Legislation and its Relationship to Services for Alcoholism and other Drug Addictions

The Committee during its hearings and deliberations has been exposed to a variety of viewpoints concerning the relationship of the law to aspects of services for alcoholism and drug addictions including prevention programs, the identification in the general population of cases of alcoholism and drug addiction, and access to assessment, treatment, and after-care services.

Many pieces of both federal and provincial legislation bear upon the field of addictions in whole or in part. Federal legislation includes the Criminal Code, Narcotic Control Act, Food and Drug Act, Criminal Records Act, Penitentiary Act, Parole Act, Juvenile Delinquents Act, among others. Provincial legislation includes Addiction Foundation of Prince Edward Island Act, Highway Traffic Act, Mental Health Act, Medical Act, Hospital Services Act, Liquor Control Act, Children's Protection Act, Jails and Prisoners Act, Pharmacy Act, Family Law Reform Act, as well as legislation pertaining to the general area of industry, business, and organized labour such as the Civil Service Act.

Of concern to the Committee was the differing interpretations given to the same pieces of legislation by separate service agencies and by referring personnel, including law enforcement officers, public health nurses, social workers, physicians, staff of correctional centres,

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clergy, probation officers, judges, guidance counsellors, and family members. The Committee has been additionally concerned that pieces of current legislation are, at present, being administered out of accord with original intent which may be caused by either ambiguity of legislation, or, in the case of agencies, a lack of resources to interpret and implement legislation. The Committee has heard, too, that certain pieces of legislation may not reflect community expectations.

Although of limited legal expertise, the Committee is of the opinion that so diverse and costly are the manifestations of alcohol and drug addictions that coherent policy and a satisfactory system of treatment and prevention services is impossible in the absence of comprehensive legislation specifically addressed to addictions. The present uncoordinated system of service and the disputes as to the respective obligations of different facilities and agencies, seem, to the Committee, likely to continue unless responsibility be clearly assigned by legislation. The Committee is fully mindful that legislation alone is incapable of resolving the serious issues caused by addictions, and recognizes that, in some cases, it may stand in the way of progressive programs. However, to properly address the serious nature of alcohol and drug addiction problems in Prince Edward Island, legislation must reflect the objectives of social policy, and may in some areas guide and authorize the development of necessary services.

The implications for resources are real and eventually, possibly, major. Comprehensive legislation could not be introduced before programs necessary to fulfill the legislation's intent are in place. The Committee, however, has studied the effects of the

comprehensive legislation in some American states such as Wisconsin and Maryland, and has been impressed by the resulting benefits. The Committee, therefore, recommends that the existing legislation pertaining to addictions be reviewed by an appropriate constituted committee with a view to the eventual formulation of a comprehensive Addictions Act. Associated with such a Committee should be a research body authorized to conduct epidemiological outcome and utilization surveys to determine the extent of the necessary resources to complement comprehensive legislation.

RECOMMENDATION # 38

That a Committee of members of the Department of Justice, the police, and the Prince Edward Island Bar Society be struck immediately by government to carry out a complete review of legislation bearing on addictions, and to bring forth comprehensive legislation.

RECOMMENDATION # 39

That developed comprehensive legislation include the following:

- a clear definition of addictions;
- definition and outline of services and programs;
- assignment of responsibility for services and programs;
- provisions for accountability;
- clarification of jurisdictions whether public or private;
- provisions for participation of community interests;

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- clarification of the liability question concerning staff, clients, and others;
- voluntary and compulsory measures;
- minimum standards;
- evaluation of programs.

RECOMMENDATION # 40

That a research body to conduct comparative outcome, epidemiological, and utilization studies be formed immediately to provide services for the Committee working on comprehensive legislation.

A crucial component of comprehensive legislation must be the definition of categories of addicts, and determination of the powers of compulsory admission to assessment and treatment programs. Disagreement over the place and justification of compulsory admission to addicts has had important disruptive effects on service development to date.

Ideally, assessment and treatment programs would be based on voluntary entry by alcoholics and those addicted to other drugs. However, since it has been the case that many addicted are unable to either recognize or acknowledge their condition, a system of assessment and treatment services based soiely on the notion of voluntarism will, in the Committee's opinion, inevitably exclude from treatment significant numbers of individuals, often those most severely affected.

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In the case of addictions, as with other types of mental disorder, the individual's right to freedom frequently conflicts with his own welfare and that of others. Which of these conflicting interests is deserving of the greater merit, and in which circumstances, is probably no more than a matter of opinion, that must, however, in the Committee's view, be clearly stated in legislation if our provincial system of service is to become more effective and less contentious. Ultimately, this judgement of value must be made by government alone. Whatever decision is made, no common agreement is likely to be found in a multi-valued society. The Committee would simply propose that any decision in this regard be based on a comparison of hypothetical outcome for the affected individual under a system that opts for liberty and under a system that opts for the individual's welfare. At present, the authority to compulsorily admit an addicted individual rests in the Mental Health Act, in which alcoholism and the criteria for admission are defined. Admission criteria for alcoholics and others suffering mental disorder hinge on the notion of danger to self or others. The Report of the Mental Health Advisory Committee of 1978 addressed itself to compulsory admissions under the Mental Health Act and made recommendations which this Committee entirely supports.

On the subject of compulsory admission for assessment and treatment, the Committee wishes to express its view that action

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of this type is justified in certain circumstances. The principle of parens patriae under which the state is entitled to protect itself from internal danger is old and hardly likely to be abandoned. Alcoholism and other drug addictions are frequently of their nature dangerous, and it seems impossible to expect that demands by communities for compulsory admission to facilities of one type or another of addicted persons behaving dangerously will disappear. Since alcoholism is, in the Committee's view, a recoverable condition, and since research does not seem to offer evidence that the outcome of treatment for those compulsorily admitted is necessarily worse than outcome for those voluntarily admitted, the Committee would suggest that humane consideration alone in some cases justifies the use of legal power to admit an individual to assessment or treatment.

The Committee wishes to emphasize that it is entirely opposed to the use of compulsory detainment in treatment programs for other than strictly defined periods. Moreover, it proposes no alteration in the criteria for compulsory admission to treatment programs as they are defined in the Mental Health Act. The characteristics peculiar to states of addiction, however, suggest that alterations in the duration of the authority to detain in treatment might be desirable to render treatment more effective. Any alcoholic at present admitted formally to treatment facilities under the Mental Health Act is subject to an authority to be detained for a period of up to thirty days. Since, in the case of alcoholism, following the process

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of detoxification which may last on average between 24-72 hours, the criteria for compulsory admission often no longer obtain, it is common for patients to be discharged before rehabilitative treatment sufficient to produce significant effects can have been given. The Committee, therefore, would recommend that under any new addictions legislation compulsory entry into treatment ordered as a result of medical examination be for a clearly defined minimum period of up to ten days, but the Committee stresses that discharge prior to the expiry of the authorized period should continue to be allowed on purely clinical grounds.

RECOMMENDATION # 41

> That a minimum period of detention for treatment be defined and authorized in new addictions legislation, for those addicted persons compulsorily admitted as a result of medical examination to treatment facilities, with the provision that discharge on clinical grounds prior to the expiry of the authorized period continue to be possible.

Appeal and review mechanisms similar to those outlined in the Mental Health Act, and as determined to be appropriate, should also be incorporated in new legislation.

Enforcement of entry into treatment programs of addicted persons by the courts, taking advantage, where possible, of medical evidence, is already permitted, and seems to the Committee, under certain circumstances to be both rational and appropriate.

In 1974, the Liquor Control Act was amended to include a definition of the "chronic alcoholic offender." Under the Act, a chronic alcoholic offender is "a person who has been convicted of an offense on three or more occasions within a period of six months, under Sub-Section 41 (2)." This Sub-Section states that "no person shall be in an intoxicated condition in a public place."

Section 53 (9) of the Liquor Control Act provides an alternative sentencing possibility for the chronic alcoholic offender. It states that "where it is found that a person is a chronic alcoholic offender, the Provincial Judge may in lieu of a fine or imprisonment, order him to accept a prescribed course of treatment under the direction of the Director of the Addiction Foundation of Prince Edward Island for a period not less than six months or not more than one year."

Section 53 (10) states that "a chronic alcoholic offender who is bound by order and willfully fails or refuses to comply with the provisions or intent of that order is guilty of an offense punishable on summary conviction."

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To date, use of this legislation has been minimal. The Addiction Foundation has probably not had a suitable facility for six-month rehabilitation programs although the Fredericton Farm would seem to the Committee to be a good setting to assist in the adequate implementation of the intent of this legislation. However, in practice the likelihood of self-discharge, in the absence of authority to detain, seems very real, with the consequences that the sentenced individual eventually returns to jail, thus entirely defeating the original purpose of the Liquor Control Act in this regard. The Committee would wish to see use of this legislation increased, but considers its practicality dubious in the absence of authority to detain in treatment.

RECOMMENDATION # 42

> That authority to detain those ordered into treatment in lieu of paying a fine or imprisonment, be clearly outlined in legislation

RECOMMENDATION #43

> That those with responsibility for applying legislation that may provide treatment in lieu of a fine or imprisonment, be encouraged to use these provisions.

On both utilitarian and human grounds the Committee views as appropriate the removal of public inebriation as an offense from provincial legislation. However, should this

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decriminalization of public intoxification become fact, the Committee would hasten to point out that the officers of law enforcement agencies must continue to be empowered to apprehend affected individuals and to take them to an alcoholism assessment and treatment centre. It is reported that at the present time, particularly during the winter months, the majority of apprehensions of the public inebriate are for his physical protection. What, then, is essentially a humane service by the police will continue to be necessary. Decriminalization of public inebriation could not be introduced with insufficient alcoholism and assessment and treatment facilities to accommodate those arrested. In the case of police apprehensions, the Committee sees the need for the receiving facilities to assume authority to detain for a limited period of, perhaps 24 - 72 hours for purposes of emergency treatment and assessment. Such authority must be defined and described in any comprehensive alcoholism legislation.

RECOMMENDATION #44

That the necessary legislation be developed to decriminalize public drunkenness.

RECOMMENDATION #45

That in the case of publicly intoxicated individuals taken to addiction treatment facilities by law enforcement officers, a minimum period of authority of up to 72 hours for detention for purposes of emergency assessment and treatment be defined in new legislation.

RECOMMENDATION #46

That all addiction facilities in the treatment system develop the capacity to detain individuals within the constraints of the law.

The Department of Social Services in its brief to the Committee drew attention to a very real need for authority to remove the violent and abusive inebriate from his family home when family members are at risk. At present, Section 12 of the Mental Health Act which states that "where a police constable observes a person: a) apparently suffering from mental disorder; b) acting in a disorderly manner; the police constable may, if he is satisfied that, c) the person should be examined in the interest of his own safety or safety of others, and d) the circumstances are such that the procedure under Section 11 would be dangerous, (Section 11 deals with procedures for bringing individuals before a judge), take the person to an appropriate place where he may be detained for medical examination."

RECOMMENDATION #47

That legislation under Sections 11, 12 and 13 of the Mental Health Act be amended to clearly state where the person should be taken and what category of person (psychiatrist, medical doctor, etc.) should carry out the examination.

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Law enforcement officers are at present unwilling under this Section of the Mental Health Act to enter private homes because of possible liability.

RECOMMENDATION #48

That the powers of entry into a domestic dwelling under certain circumstances be made explicit in any new legislation.

While the Mental Health Act in Section 20 provides for transfer of individuals between psychiatric and alcoholic rehabilitation facilities, the practical application of this has frequently been fraught with difficulties. The legislation must be clarified concerning who is responsible for the individual patient transferred under this authority.

RECOMMENDATION #49

That legislation regarding transfer of patients be reviewed in order to clarify it.

Related to the question of access to services, and perhaps more importantly, where and in what context such services should be provided, is the matter of continuing the use of jails to hold individuals found to be intoxicated in a public place.

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RECOMMENDATION #50

That, with reservation, the Jails and Prisoners Act be amended to outline clearly that only under exceptional circumstances should anyone be admitted to a jail/lock-up facility for being intoxicated in a public place, and only after a medical assessment has been performed.

The reservation is one of strictly limiting the use of jails to hold individuals not considered criminal. If, as discussed in the body of this Report, it is accepted that alcoholism is a disease, then it should follow that it should be dealt with in a medical/health context and not in a criminal context. The Committee is mindful, however, that where criminal behavior is combined with an addiction problem, there is no doubt of the propriety of utilizing jails and correctional facilities as holding units, provided, of course, the appropriate provisions of criminal law are followed.

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- The Law as it Relates to Prevention

The Committee examined in a broad context areas of the law as it relates to prevention. One example out of several pieces of legislation that require review and possible amendment, and, perhaps, improved enforcement and consistent application, is the Liquor Control Act.

Among many regulations dealing with the sale and distribution of liquor, this Act provides for inspection of licensed premises, and the Committee has become aware that the manpower available for this important duty is in short supply and may even be felt by some to be inadequate.

RECOMMENDATION # 51

That the staff complement of liquor inspectors with authority under the Liquor Control Act be increased with particular attention being paid to:

- the inspection of licensed premises;
- the use of mandatory identification;
- under-age drinkers.

Despite the abandonment of prohibition over 30 years ago, and despite the ready availability of alcoholic beverages in licensed clubs, bars, and lounges, the illegal enterprise called "bootlegging" still flourishes in Prince Edward Island. The lack of clarity in the Liquor Control Act regarding the burden of proof and the authority of the law enforcement agencies are often hindrances to the prosecution of these offenders, and, at times, the police themselves are made to appear the law breakers.

RECOMMENDATION # 52

That the Liquor Control Act be reviewed with a view to shifting the burden of proof to the bootlegger to account for his supplies of liquor.

The question of the legal drinking age has raised problems in this province as it has across the continent. It was made clear in many briefs received by the Committee that there is a growing number of people in Prince Edward Island calling for the raising of the drinking age. It is obvious that lowering the drinking age to 18 in 1974 had the effect of exposing many more young people directly to alcohol. The advantages and disadvantages of raising or lowering the drinking age could be discussed interminably, but it is the Committee's opinion, after considering that the legal drinking age has already been raised in two Canadian provinces, and that such a move is being considered in other constituencies as well, that the drinking age in this province should be raised to 19.

RECOMMENDATION # 53

That the drinking age in Prince Edward Island be raised to 19, thus making the age uniform in the Maritime Provinces;

RECOMMENDATION # 54

That the government take steps to promote a discussion of the legal drinking age at the national level with a view to making it uniform.

Following is a list of the legal drinking ages across Canada:

PROVINCE	AGE	PARTICULARS
British Columbia	19	Was 21 - April, 1970
Alberta	18	Was 21 - April, 1971
* Saskatchewan	19	Was 18 - Sept. 1976
Manitoba	18	Was 21 - Aug. 1970
* Ontario	19	Was 18 - Dec. 1978
Quebec	18	Was 20 - July, 1971
Northwest Territories and Yukon	19	Was 21 - July, 1970 Feb. 1970
New Brunswick	19	Was 21 - Aug. 1972
Nova Scotia	19	Was 21 - April, 1971
Newfoundland	19	Was 21 - July 1972
Prince Edward Island	18	Was 21 - 1974

* Raised drinking age

It has been brought to the Committee's attention that what appears to be the ready availability of special permits, and particularly their use to stock pile liquor, is a matter of concern, and that legislation by which such permits and, indeed, all licenses are granted should be reviewed with a view to closing any avenues by which legislation is being circumvented.

RECOMMENDATION # 55

That the procedures and criteria under which licenses and special permits are granted, be reviewed and tightened.

It has been brought to the Committee's attention that a provision under the Liquor Control Act that is, in effect, unenforceable, is that dealing with the transportation of open

liquor in automobiles. Not only is this an area where young people are exposed to alcohol, but perhaps more disturbing, it may subject them to its irresponsible use and to the added hazards associated with drinking and driving.

RECOMMENDATION # 56

> That the experience since the amendment regarding the transportation of open liquor in automobiles was proclaimed in September, 1975, be evaluated with a view to re-writing the legislation in order to clarify it and make it enforceable.

The question of prevention is seldom addressed in legislation, and it is indeed ironic that, in Prince Edward Island, the agency primarily responsible for addiction programs does not have a clear responsibility in legislation for prevention programs, although the Addiction Foundation Act does give some degree of priority to programs of this nature.

RECOMMENDATION #57

> That prevention be given appropriate attention in legislation, by at least assigning special prevention responsibilities to particular services or agencies.

In the area of prevention and early identification, particularly in labor-management relations in business, industry, and the public service, attention should be given to the need for legislative action. The Committee considers the concept of

alcohol/addiction treatment as an employee right, and management should acknowledge this right. Correspondingly, the employee has a responsibility to co-operate in his rehabilitation by following the treatment program and educating himself in the nature of his illness.

The Civil Service of the province is an example of employees having the opportunity, through regulation, to participate in alcohol and addiction treatment programs while continuing to share in employee benefits such as sick leave. The Committee understands that many union and association contracts here and elsewhere also include this concept.

RECOMMENDATION #58

> That employees' rights and duties regarding treatment for alcoholism be given appropriate attention in labor-management negotiations, and be reflected in other pieces of provincial legislation and regulations.

The Committee has addressed itself in the chapter on Prevention to the question of the control and regulation of the use and abuse of prescription drugs. While Criminal Law may be an avenue through which certain abuses can be responded to, the Committee would wish to see changes in provincial legislation to assist in controlling abuses, and has so recommended in that section of the Report.

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The Committee suggests that the Pharmacy Act require that all medication, which, when mixed with alcohol or other substances may have an impairing effect, be labelled with a message to this effect. Similarly, in a manner parallel to that adopted for tobacco, the Committee suggests that consideration be given to placing a label on alcohol products to the effect that the contents may be injurious to the consumer's health.

In focusing its attention on the Highway Traffic Act, the Committee felt that the province has an opportunity and, indeed, a responsibility to ensure that operators of motor vehicles are properly and carefully licensed. In a broad sense, this would be a preventive measure.

There is felt to be a touch of irony in this age of the machine when an owner of a motor vehicle is required annually by law to ensure that his vehicle is in proper and safe operating condition, while no such requirement exists for himself. The Committee feels that consideration should be given to modifying the application-granting process, and the process of renewal of operators' licenses, in such a manner that information on whether or not an applicant has an addiction or other problems that could result in a reduced ability to operate a motor vehicle properly can be gathered. This

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information could be forwarded to the Medical Advisory Panel mentioned below to help them in their determinations on granting or reinstating licenses.

In addition, the Committee suggests that new drivers be exposed to a short course dealing with driver's responsibilities, and the liabilities of operating a motor vehicle while drinking or using drugs. It is a logical conclusion that, in the long run, such action would reduce highway accidents, injuries, property damage, deaths, medical and social costs, as well as reducing insurance premiums, particularly for young drivers in this province.

In addition, the reinstatement of drivers' licenses, particularly where drinking and driving offenses have been pertinent to the loss of the license, should be subject to medical examination.

RECOMMENDATION #59

That the criteria set and the procedures used to obtain an operator's license be reviewed with a view to improving highway safety.

RECOMMENDATION #60

That a Medical Advisory Panel to the Highway Safety Division be established to make judgements on granting or reinstating the operators' licenses of applicants referred to it.

This would result in a sharing of responsibility for decisions, where, in the present circumstances, it may often be a difficult and troubling decision for a single medical professional to make.

The Committee is aware of the Driver Rehabilitation Course, coordinated by the Highway Safety Division, which is required of those who have been convicted of repeated offenses related to impaired driving, and of those refusing or failing the breathalyzer test. This effort is to be commended, but the Committee feels that the provisions in law making the course mandatory are not broad enough in scope and should be extended to include all individuals convicted of drinking and driving-related offenses under the Criminal Code.

RECOMMENDATION # 61

That regulations under the Highway Traffic Act be amended with a view to requiring all individuals convicted of drinking and driving type of offenses under provisions of the Criminal Code to participate in a Driver Rehabilitation Course.

The Committee is mindful that larger numbers in the course could mean increased staff and a resulting increased cost. It is felt, however, that since this is a public information program, the number of participants could be substantially increased using the same resources. Should this and other actions recommended by the Committee prove effective, a reduction in demand for programs such as the Driver Rehabilitation Course should result in the long run.

Frequently, full investigation of many highway accidents, where there are obvious signs of impairment due to alcohol or other drugs, is seriously curtailed by the present limits placed on means of gathering adequate evidence. The Committee feels that the concept of "implied consent" should be adopted on Prince Edward Island as a condition of acquiring an operator's license.

RECOMMENDATION #62

> That upon first application, or application for renewal, and before receiving an operator's license, a condition of obtaining that license should be that, in the event of an accident, the individual gives consent to the police and/or the medical profession to obtain a blood and/or urine sample if breathalyzer samples and/or other evidence is deemed appropriate.

Essentially, this recommendation would provide solid evidence upon which to proceed and would at the same time, exclude medical and law enforcement personnel from liability concerns. It should also encourage increased responsibility in the operation of motor vehicles, and, while being difficult to measure, may well serve as a deterrent to those who drive while under the influence of alcohol or other drugs.

The Committee is aware of the present inconsistency in the application of the procedures by which second and third

convictions in impaired driving cases are put before the courts. Steps should be taken to ensure that information in the central registry is accurate, complete, and current. It may be that present methods of maintaining records require refinement.

Since it probably does not require legislation, the Committee urges government, for educational purposes, to make the public aware of the policy on procedures used for those charged with second and third offenses under impaired driving laws.

Some concern was expressed over the lack of legislation regarding the merchandising of solvents such as glues, polishes, and aerosol substances. The Committee does not have specific recommendations in this regard, but feels action could be taken by merchants and consumer groups aimed at keeping these solvents out of the hands of children.

Regulations pertaining to the advertising of alcoholic beverages through the media came under discussion. The Committee feels that government should maintain its present position of banning advertising of alcoholic beverages from the media, and urges it to continue its efforts to have such advertising banned from Cable TV, the latter point so recommended in the chapter dealing with Prevention.

RECOMMENDATION #63

That government continue its present policy of allowing no advertising of alcoholic beverages in media within the province.

The use of legislation as an element of preventive health care strategy is an action which governments have tended to be conspicuously reluctant to undertake, and one which may involve political disadvantage. Locally, it is to be noted that seat-belt legislation has been rejected. It has not been for the Committee, nor has it fallen within its sphere of competence, to advise government on what is politically expedient or inexpedient.

The recommendations on preventive legislation, if adopted, would undoubtedly represent real changes in social policy, reflecting a determination in government itself to courageously address some of the complex social factors which contribute to the growing phenomenon of addictions. The Committee views its recommendations in this area to be sound, but only government can decide as to the wisdom of their application.

- Additional Issues

a) Privacy of Information - Confidentiality of Records

Section 10 of the Addiction Foundation Act gives employees of the Addiction Foundation the authority to maintain confidentiality of records, an exception being where the consent of the individual involved is obtained before releasing information.

The issues of confidentiality, the right to data collection, and the ownership of information, are not new, and are areas of extreme sensitivity requiring great caution. Certainly, with the increased use of computer programs in the compilation and storage of information, the need for such an examination and future direction becomes all the more obvious.

It is evident that agents of government as well as private agencies will be involved in gathering this information, and these should include the Department of Health, (Mental Health and Public Health Nursing Division, etc.), Hospital Services Commission, Medical Society, Department of Justice, Department of Education, Department of Social Services, Addiction Foundation, as well as federal agencies such as Canada Manpower, Unemployment Insurance, and the Canadian Corrections Services.

RECOMMENDATION #64

> That the provincial government examine as soon as possible the whole question regarding confidentiality, the right of data collection, ownership of information, exchange of information, and develop policy positions on these matters.

b) Civil Legal Aid - Legal Services:

The Committee has been reminded of difficulties, particularly in family disputes over desertions, custody, and support, which are attributed to addiction problems, since many of those so victimized lack representation in advancing their

cases with government agencies or before the courts. People in these situations, and trying to cope with the negative ramifications of addicted people, are in the worst position to be their own advocates.

RECOMMENDATION #65

That the province establish a method whereby individuals may have access to legal services to exercise their rights in dealing with the negative aspects of addiction problems.

- Federal Legislation:

A number of pieces of federal legislation relate to the area of addictions, and responsibility for the review of these rests with the Federal Government. These pieces of legislation, nevertheless, frequently have a direct relationship to activities in the area of addictions at the provincial level. The Committee puts forth the following view, therefore, to encourage the Provincial Government to review this legislation for its impact on activities related to addictions within the province. Among the federal acts to be considered are the Narcotic Control Act, Food and Drugs Act, Criminal Records Act, and the Criminal Code of Canada.

RECOMMENDATION # 66

That the province make its position known to the Federal Government on the matter of addictions and, where a position does not exist, to develop one.

Some discussion took place in the Committee over the question of the decriminalization of marijuana. This matter was raised by the recent media attention to the question of whether or not the Narcotic Control Act is criminal law, and whether or not a person convicted under this Act has a criminal record. The Committee makes no recommendation on the matter, noting simply that some briefs received advised against the decriminalization of marijuana, a view held by the majority of this Committee.

It was pointed out to the Committee that the Department of National Health and Welfare is gathering information not only on persons found guilty of possession of narcotics and drugs, but also on those alleged to be drug users. It was felt within the Committee that it may perhaps be sufficient that this information is being gathered by law enforcement agencies, but it is suggested that this area be studied by the provincial authorities with a view to the social costs, benefits, and undesirable implications of these practices.

There are some eight to ten sections of the Criminal Code relating to family behavior following abuse of intoxicants by a family member. These provisions include breach of the peace, contributing to delinquency, assault, keeping the peace, providing necessaries for dependents, and restraining orders. These are sensitive areas requiring clarification where expectations on law enforcement agencies are often beyond their ability to respond.

RECOMMENDATION # 67

That the Department of Justice undertake a systematic review of the Criminal Code provisions that have potential for facilitating intervention into and management of family disputes/violence attributable to abuse of alcohol and drugs.

While the Committee does not encourage the use of Criminal Legislation in intervening and responding to domestic disputes of an aggressive nature, the reality of some situations, however, requires the application of this legislation.

RECOMMENDATION # 68

That in situations where satisfactory remedies short of placing the matter before the courts cannot be found, government through the Department of Justice, should develop mechanisms to bring matters such as domestic disputes which may involve assault first before the family courts, as opposed to the practice of bringing them before provincial court where proceedings are more open to the public.

The Committee recognizes that the area of domestic disputes is a delicate one, but one often requiring police intervention. Since relationships in these circumstances are often fragile and tenuous, deteriorating in the past to such a level as to result in the death and injury of officers, the

Committee feels that police should have special training to increase their competency in these situations.

RECOMMENDATION # 69

That the province, through agencies such as the Atlantic Police Academy, develop and administer to all law enforcement people a minimum standard of training in the area of crisis intervention.

APPENDIX

THE DISEASE MODEL OF ALCOHOLISM

The disease model of alcoholism, which, admittedly, has been subject to prolonged assault in recent years, appears to the Committee on balance to have well stood the test of time, and to continue to be indispensable as a guide to treatment and social policy. The pragmatic advantages which it holds over other models in these major areas seem very real. Institutions and programs, in Prince Edward Island at least, that have abandoned it, do not appear to have fared particularly well.

Siegler and Osmond, whose important research of models has been influential to this Report, have suggested that a useful model must give practical guidance to all involved in a problem such as alcoholism in all its aspects, and must, above all, be comprehensible and acceptable to the public at large. The disease model fully meets these criteria.

A model, it should be noted, is essentially an abstraction, existing independently of truth or falsity, whose value can be judged only by its usefulness. Clearly, different models will inevitably tend to be applied in different settings, and by individuals of different background and training, and in different stages of treatment, but in matters of general social policy, the disease model, despite admitted short-comings, seems the best suited for future development. The Committee holds that, if

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properly understood, the disease model has the flexibility and scope to enable the harmonious co-operation of professionals of different disciplines to occur in the same clinical setting.

There is nothing at all new in the designation of alcoholism as a disease. Benjamin Rush, in his Treatise on the Mind, published in 1812, clearly described the excessive use of "ardent spirits" as a disease which "originates in free agency and by habit becomes necessity," a description whose elegance has barely been surpassed in the subsequent passage of years.

Rush noted, in passing, that one-third of the inmates of the Pennsylvania Hospital, in his time, were victims of alcohol. Since the early nineteenth century, the few physicians who have deigned to work clinically with alcoholics have urged their colleagues to understand and treat alcoholism as a disease, although their entreaties fell largely on deaf ears. It was not until 1948 that the World Health Organization included alcoholism as a disease, as opposed to certain derivative conditions, such as alcoholic psychosis or alcoholic cirrhosis. This step was followed by The American Medical Association six years later, largely at the prompting of Alcoholics Anonymous.

The epistemological difficulties inherent to concepts such as disease and health are by no means easy to solve, and disagreement has continued since the time of Hippocrates. Today, within medicine itself, certain definitions of disease are not universally acceptable, nor are the criteria for inclusion in this category.

The endopathological concept of disease developed by Rudolph Virchow has offered a fairly rigorous foundation for the concept, but would be regarded by many as too restrictive for general application to medical practice and the inclusion criteria are by no means as clear as might appear at first glance, nor are they immune to disputation.

In the case of alcoholism, peculiar difficulties arise in consideration of its nature. Some definitions, such as those of Adams who views alcoholism as the effects of excessive drinking, would certainly seem to place the condition squarely into the Virchowian category of disease since demonstrable cellular changes occur as a consequence of the ingestion of toxic doses of alcohol, and may reasonably be assumed to occur in brain tissue with likely behavioral effects.

Scadding's nominalist definition of disease referring to those characteristics by which an individual deviates from the mean and which confer biological disadvantage certainly must apply to

alcoholism, a condition which undeniably shortens life and causes considerable social disability and impairment of functioning.

In arguing the legitimacy of understanding alcoholism as a disease, the Committee proposes a simple materialist hypothesis; that is, that it is not possible to conceive of mental events, nor the behavior from which they may be inferred, as occurring in the absence of a corresponding physio-chemical change in the brain. Thus, a biological diathesis of a pathophysiological kind is postulated as a necessary, if not sufficient, cause of alcoholism. Social, cultural, and psychological factors are frequently contributory, as indeed is the case for all diseases. That such a pathophysiology remains to be clearly demonstrated, despite the availability of some supporting evidence at present, may reflect more on the available instruments and techniques of measurement, rather than on any inherent weaknesses of the hypothesis itself, which has certainly proved useful when applied to the psychotic illness. The postulated biological diathesis is best explicable on a genetic basis.

As Jellinek stated in his book, The Disease Concept of Alcoholism Revisited, the designation of any condition as a disease is ultimately arbitrary, and likely to endure only if its utility in conveying meaning and experience persists over time,